

A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED IN  
THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

1963



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IN THE UNITED STATES

*by*

*The Committee on Residential Care*

Volume II

NATIONAL ASSOCIATION FOR RETARDED CHILDREN  
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## FOREWORD

### The Need for the Survey

The advent of the parent movement in behalf of retarded children and subsequent organization of Associations for Retarded Children at a local, state and national level created an unprecedented increase of citizen interest in the welfare of thousands of mentally retarded individuals living in State-supported residential centers throughout the country. Members of the Committee on Residential Care of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN believed that parents must become generally knowledgeable on the subject of institution care and well informed as to conditions, techniques and trends in the various States if they are to develop into the most effective co-workers with professional people in improving the quality of residential care.

In order to provide the basic information on residential care, this Committee undertook a survey of the residential centers for the retarded throughout the nation.

### Purpose of the Survey

The ultimate goal of the survey is to produce a report which might well be termed an instrument of understanding. Such an instrument should bring about a more intelligent understanding of the complex operations involved in residential centers for the retarded and a better understanding of the current programs, conditions and trends in the various States. In addition, the report should help those who work in this field to understand the specific aspects of institution care which are of importance to parents, and why.

### How Was the Survey Developed and Carried Out?

This project was initiated and carried out by sixteen persons serving as the Committee on Residential Care of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN. Specific aspects of institutional programming were assigned to various persons on the Committee. In 1961, a detailed questionnaire was prepared and submitted to the administrative officers

of 111 State-supported institutions for the retarded in fifty States. The questionnaire was preceded by a personal letter to the head of each institution which stated the reason for the project and asked for cooperation in giving the information for his institution. The questionnaires were divided into sections in order that they might be studied and answered by the various staff members responsible for a specific aspect of the total institutional program. Thus, instead of reflecting the opinions and ideas of only one or two persons in each institution, the questionnaires in many cases brought in replies from persons representing all disciplines on the institutional staff, thereby obtaining a broader, more comprehensive view of the total programs.

Of the 111 institutions polled, 99 or 89 percent returned the completed questionnaires. In several cases one or more institutions failed to return certain sections but the majority of those responding answered the entire questionnaire. Each individual Committee member then made a study of the returned questionnaire in his or her specific area of assignment. The data was organized and analyzed, and a report was written on each section by the responsible individual.

In addition to the questionnaires, other resource material was utilized by all committeemen. This material included literature available from various sources pertaining to their specific area of study. The publications *MENTAL HOSPITALS*, *THE AMERICAN JOURNAL OF MENTAL DEFICIENCY*, and numerous other professional Journals and articles relating to residential care were used as resource materials. Ideas were also drawn from numerous papers and talks presented by workers in the field of residential care and related areas. In addition, personal visits were made by NARC staff and/or members of the Committee on Residential Care to a majority of the 111 institutions. Conferences were held with administrative officials of the State, as well as with the administrative officials and staff members of the institutions themselves.

### Reporting of Results

The survey is published in two volumes. The first, entitled CHARGES FOR RESIDENTIAL CARE OF THE MENTALLY RETARDED, was released at the 1963 annual convention of the National Association for Retarded Children.

This volume contains those parts of the study addressed to the day to day operation of the institutions. The data reported, the problems raised and the recommendations proposed present a vivid picture of programs in institutions today and project directions for the future.



John G. Fetting, President  
National Association for Retarded Children

## ACKNOWLEDGEMENTS

A survey of this scope would have been impossible to carry out without the cooperation of hundreds of individuals. Our most sincere appreciation is extended to the Administrative Officers and staff members of the 99 residential centers who participated in the survey by answering the detailed questionnaires that were submitted to them. The majority of State Department officials were most cooperative in furnishing the necessary statistical information for the study on charges and to them we would also express our thanks. Members of the committee obtained much constructive help and advice on their individual sections from numerous persons throughout the nation who are working in the field of residential care, and to these interested individuals we say a collective "thank you". We are grateful for the excellent cooperation of the NARC office staff during the three years it took to bring the survey to its conclusion, especially to Mrs. Shirley Marciano who was assigned the overwhelming job of copying and filing the data that was returned as well as typing the final manuscript. And finally, we are indebted most of all to Dr. Gunnar Dybwad, NARC Executive Director and Mr. Allen Menefee, NARC Consultant on Residential Care for their patient and constructive help from beginning to end.

### The Study Committee

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PART II. ADMISSIONS AND PRE-ADMISSION SERVICES



## I. INTRODUCTION

The emotional shock experienced by parents upon admission of their retarded child to an institution is often as traumatic as that which they undergo when they first discover their child is retarded. Appropriate pre-admission and commitment procedures can, however, prevent much of the distress so often felt by both the family and the retardate. The lessening of acute problems at the time of commitment will also tend to establish a more satisfying basis upon which to build and maintain future family-resident relationships.

Maintaining close contact with the family is of special importance in light of the current concept of the role of the institution as a training center from which some residents may at a future time return to their families. In past years, more often than not, the institution was considered as a terminal placement for the retardate. A more recent and widely accepted philosophy sees the residential center as only one part of a total constellation of State and community oriented services. Under this philosophy, residential care is not looked upon as a last resort. Rather, it is accepted as a temporary situation which most appropriately meets the needs of the individual retardate and his family at certain periods. The acceptance of this philosophy would of necessity demand more fluid, less rigid commitment laws as well as voluntary admission procedures, thus enabling the retardate to move into and out of residential care as his own needs and/or the family situation may require. Such a concept would also necessitate a close cooperation between institutional personnel and the family if their efforts are to prove successful in keeping the family ties strong and unbroken.

In an effort to determine present practices and to gain an indication of current trends in admission procedures and maintaining family relationships, a questionnaire was submitted to the State-supported residential centers for the retarded in our fifty States. One hundred and eleven centers were polled. Responses were received from 93 centers, representing 46 States. On the basis of the analysis of the information received, NARC has attempted to point out specific problems that exist, to evaluate current practices, to draw conclusions and present recommendations that will serve to lessen "admission shock" and to maintain closer family ties.

## II. DATA FROM QUESTIONNAIRE ON PRE-ADMISSION PROCEDURES AND MAINTAINING FAMILY-RESIDENT RELATIONSHIPS

Questions on pre-admission procedures were divided into three distinct areas: Commitment Laws; Diagnostic and Counselling Services and Waiting Period for Admission. The data obtained is presented below.

### Commitment Laws

1. a.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>
Please check the State legislative requirement for accepting retardates for admission into your institution.	Legal commitment <u>26</u>
	Voluntary admission <u>7</u>
	Either legal comm. or voluntary adm. <u>57</u>
	Only by transfer from other institutions . <u>3</u>
	No answer <u>0</u>

The survey also requested the reference number and copies of statutes regarding admission into institutions for the retarded. It was interesting to note that the earlier laws passed were geared primarily to legal commitment while those passed in more recent years, moved in the direction of voluntary commitment.

b.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>
Based on your experience, which of the three alternatives under 1.a . do you prefer for admitting residents to your institution ?	Legal commitment <u>17</u>
	Voluntary admission <u>20</u>
	Either legal comm. or voluntary adm. <u>43</u>
Why?	No answer <u>13</u>

The question concerning the administrator's preference in commitment laws brought a wide variety of answers. Typical comments of some who expressed preference for legal commitment were:

- "Legal commitment gives institutions complete authority to make plans for residents. Gives parents lifetime assurance."
- "Gives better control over the children with less interference from parents who do not understand the child's problems."
- "Because they have at least been screened by court-appointed physicians."

The comments of some who expressed preference for voluntary admission were:

- "Voluntary is preferred in most situations. They involve the family directly, are more in line with the therapeutic goal of the school, do not involve 'civil rights', and are easier to process. "
- "We have found parents to be more cooperative and willing to plan for their child's future if admission is on a voluntary basis and they have a part in the planning. "
- "In voluntary admissions parents are more able to assume the natural role of responsibility for their children's welfare. Legal commitment often adds to the emotional problems in connection with the mental retardation in ones child. We do not like the stigma attached to commitments through courts."

Administrators preferring either legal commitment or voluntary admission (not quite half of those responding) expressed themselves as follows:

- "Legal commitment in cases involving serious social problems and voluntary admissions for care and training when these facilities cannot be provided in the home or local community."
- "Provides flexibility whereby needs of patient, family and community can be met adequately."

- "Permits those who want to admit on a voluntary basis , to do so and also permits the court an opportunity to have problem cases committed."

c.

QUESTION	NO. INSTITUTIONS	
Do you consider the majority of the physicians who serve on legal commissions for sending residents to your institution to be knowledgeable in the field of mental retardation?	Yes	<u>32</u>
	No	<u>22</u>
	Rarely	<u>22</u>
	No answer	<u>17</u>

Although comments were not requested on the above question, the large majority of questionnaires contained comments on this and the following direct quotations were somewhat representative:

- "Rarely. In terms of diagnosis the majority of physicians are quite competent, but it is our experience that most of them do not keep abreast of latest trends in planning for the retarded. They are not cognizant of community resources or of institutional facilities and limitations. "
- "While conditions are improving, older medical men got nothing but a passing reference to mental retardation as an afterthought to limited psychiatric lectures. "
- "Physicians are generally knowledgeable in the diagnosis of retardation; however, they are quite deficient in their knowledge of the psychological and social factors involved."
- "Rarely. This is why we do a pre-admission evaluation,"

Diagnostic and Counselling Services

2, a.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Do parents have diagnostic and counselling services regarding their child available either at the Institution	Yes	<u>80</u>
Itself or at a community clinic before the final decision is reached for placement ?	No	<u>6</u>
	No answer	<u>7</u>

Comments on this question indicated that while most institutions have such a service available, the majority depended also on community facilities for parent counselling prior to their choice of residential care. A number of answers were indicative of a lack of communication between the institutions themselves and the various community agencies serving retarded persons on a local level.

b.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Are parents encouraged or required to visit the institution one or more times before the admission of retardate?	Yes	<u>78</u>
	No	<u>10</u>
	No answer	<u>5</u>

Some typical comments relative to the above question appearing on the questionnaire were:

- "All parents of voluntary commitments are required to visit the area in which their child will be placed before commitment. All parents of court commitments are encouraged to visit the institution."

- "Encouraged in some cases. County welfare people handle pre-admission."
- "Neither. They may visit if so desired. "

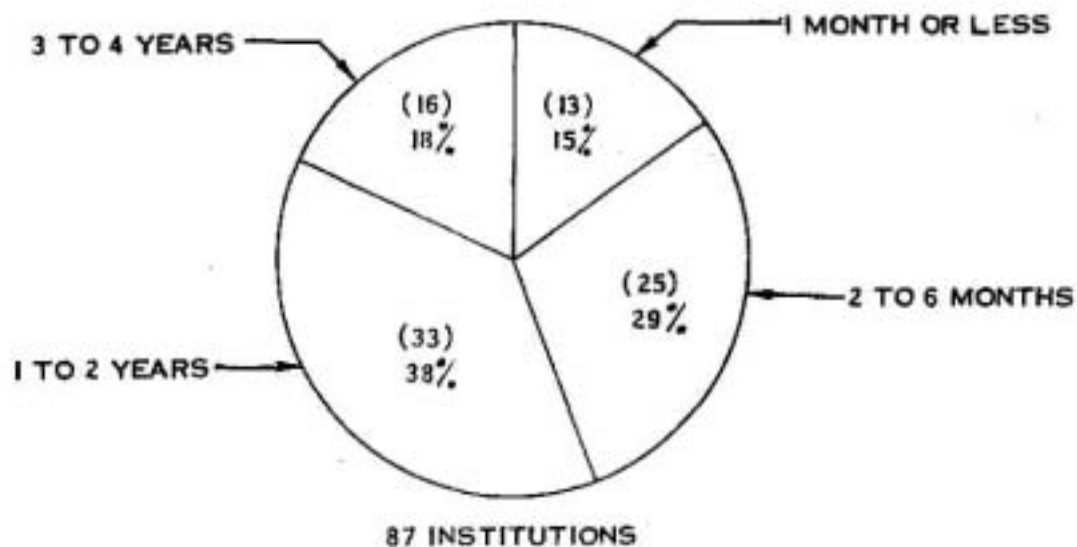
From these and numerous other similar comments it appeared that this is a matter which seemed wholly dependent upon the philosophy of the current administration in an individual institution.

c. \_\_\_\_\_

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	<u>By whom are such orientation sessions conducted?</u>
If the retarded person is admitted are orientation sessions held for the parents ?	Yes <u>64</u> No <u>27</u> No answer <u>2</u>	- Superintendents <u>20</u> - Social Workers <u>55</u> - Chaplains <u>8</u> - Psychologists <u>18</u>

Of the 93 institutions responding to this question, 30 use a team approach in the orientation sessions. Besides those listed above, these participated on occasion: nurses, attendants, educators, medical staff members, other parents.

3. a. What is the average waiting time between the acceptance of an individual's commitment to your institution and the actual admission to the institution ?



AVERAGE WAITING TIME BETWEEN ACCEPTANCE OF COMMITMENT  
AND ACTUAL ADMISSION

In light of the fact that in more than half of the institutions, parents wait from 1 to 4 years for their child to be admitted, the following question regarding services to those awaiting admission takes on added significance.

- b. When a retardate has been officially accepted for the waiting list and the family has been advised of the probable length of time before admission, what, if any, specific services are rendered by the institution to assist the family in the interim?

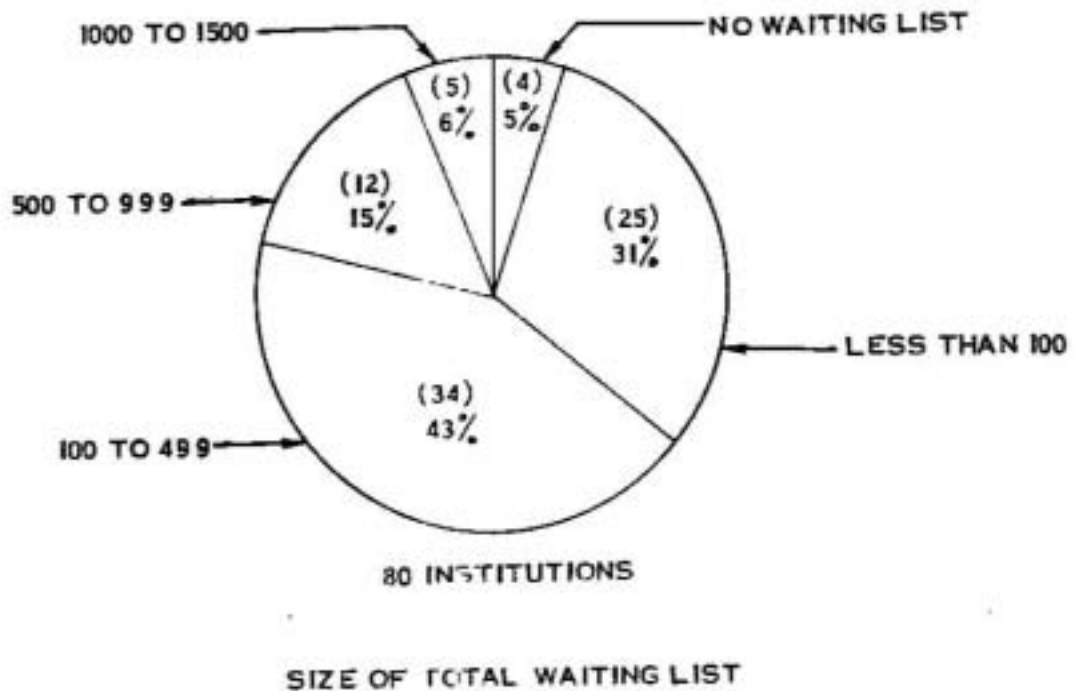
Answers to this question indicated that the majority of institutions refer families to local community agencies. Several indicated that they send social workers for home visits or hold interviews or orientation sessions at the institution for parents during the waiting period. 24 indicated they had no service at all for parents during the interim. In cases where social workers were sent into the homes they provided the following services:

- Assisted in home management problems — training, feeding, etc.
- Assisted in finding foster homes when this seemed advisable.
- Suggested places where private placement could be made.
- Referred families to local Associations for Retarded Children.
- Provided families with suitable reading material on mental retardation.

A number of the institutions indicated that until a retardate actually became a resident they felt he was the responsibility of the local social service agency.

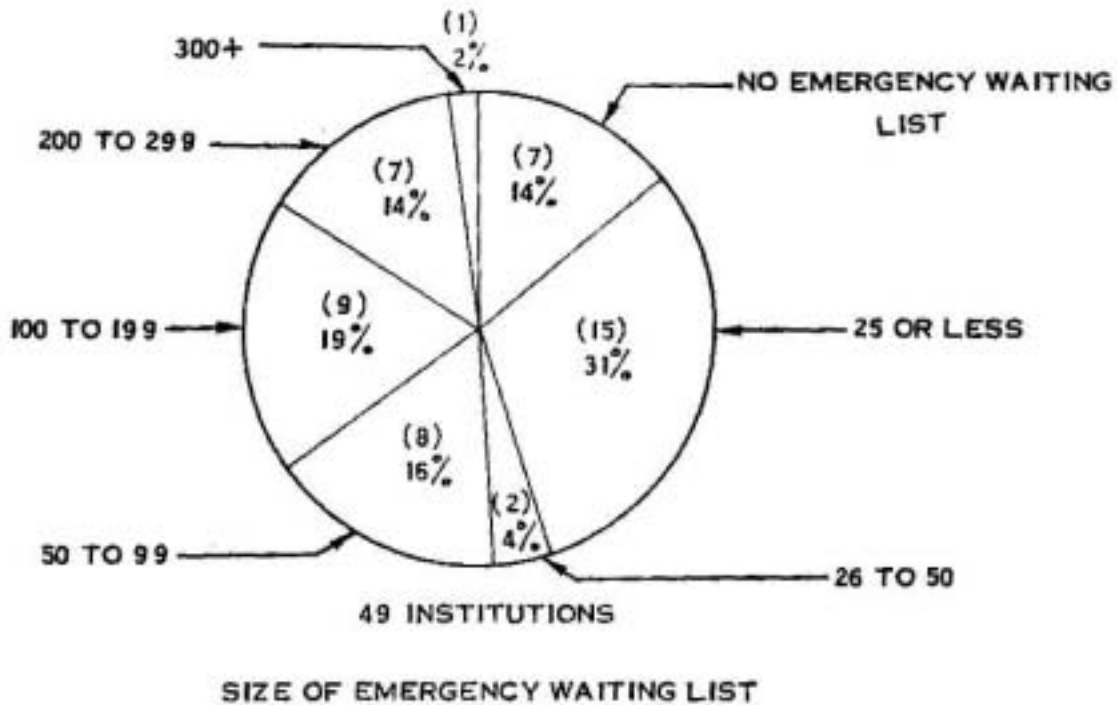
The primary reason given for lack of adequate service to parents during this interim period was "not enough personnel".

- c. What is the approximate number of patients on your present waiting list?





Eighty institutions reported waiting lists totaling 25,939 (including emergency or preferred list and regular list). By interpolation, waiting lists for all State institutions would exceed 36,000. Almost one-third of the institutions have waiting lists of less than 100.



Since 44 institutions did not answer this question, the above statistical comparison was made on the basis of the responding 49, which reported a total of 4,199 persons whose cases were regarded as emergencies.

d.

QUESTION	NO. INSTITUTIONS	
Has your waiting list been re-checked within the past three years to determine the status of those who may have been placed there three or more years ago ?	Yes	<u>75</u>
	No	<u>2</u>
	No answer	<u>16</u>

e.

QUESTION	NO. INSTITUTIONS	
Does your institution routinely refer the parents of your residents to local or state Associations for Retarded Children?	Yes	<u>47</u>
	No	<u>8</u>
	On occasion	<u>32</u>
	No answer	<u>6</u>

Maintaining Family-Resident Relationships

Questions pertaining to this section were divided into three general areas: policies on visiting and contact between families and residents in the institution; policies on home visits; efforts to maintain contact with the family in other ways. Data in answer to these questions appears below.

1. a.

QUESTION	NO. INSTITUTIONS			
Please indicate policy on length of time between admission and first visit from the resident's family.	No restrictions	<u>27</u>	4 weeks	<u>26</u>
	1 week	<u>4</u>	5 weeks	<u>2</u>
	2 weeks	<u>12</u>	6 weeks	<u>19</u>
	No answer	<u>3</u>	Longer	<u>0</u>

These answers indicate that at present there seems to be little unanimity of thought on this policy. The trend, however, appears to be in the direction of shorter periods of time or no restrictions at all. With a total of 43 institutions permitting visits either without restrictions or within a two week period and a total of 69 permitting visits without restriction or within a four week period, the indications are that, in general, a greater opportunity exists for maintaining closer family ties for those who have been newly institutionalized.

b. What are your regulations regarding regular visiting privileges?

Here again, policies were divergent. Answers ranged all the way from "Everyday - we maintain a flexible policy," to "Specific hours week days. For Sunday and holidays prior notice of intent to visit is required,"

There appeared to be no correlation between the size of an institution and its visiting regulations; some of the very largest maintained flexible visiting hours and appeared to encourage regular family contacts, while others of the same size seemed to have more, rigid regulations in regard to visiting privileges. Frequent mention was made of the therapeutic value of family visits to the resident in an institution.

QUESTION	NO. INSTITUTIONS	
Are parents encouraged or permitted to feed, dress, bathe or otherwise assist in the direct care of their children ?	Encouraged to help	<u>16</u>
	Permitted to help	<u>35</u>
	Not allowed	<u>13</u>
	No answer	<u>29</u>

According to specific comments given on this question, parental assistance is encouraged and permitted more often in feeding the children than with dressing, bathing or otherwise working directly with the child. It was interesting to note that 29 institutions gave no answer to this question. Some typical comments which appeared on the questionnaires in response to this question were:

- "No person except employees permitted on wards. Parents and relatives visit in areas set aside for this purpose,"
- "We encourage this but long distances do not make such a reality."
- "This is not our general practice."
- "No. Our limited staff is not able to permit this."
- "Sometimes. On an individual basis parents are permitted to do all these things. "
- "In the infirmary only. Elsewhere, they may check on cleanliness, clothing, care, etc., but parental attempts to reorganize systems have proven to be offensive to employees who are doing their best."

d. What are your regulations concerning home visits?

The majority of institutions responding permit home visits when a request is made by parents depending on the condition of the individual, the conditions in the home, and if it does not interfere with the resident's school or treatment program. Further study of handbooks and brochures on

visiting policies indicate some rather rigid rules. However, a growing number of institutions encourage home visits.

2. a.

QUESTION	NO. INSTITUTIONS	
What effort is made to keep in contact with parents of your residents by a regularly published newsletter?	Monthly	<u>28</u>
	Weekly	<u>1</u>
	Quarterly	<u>1</u>
How often is it published ?	None	<u>61</u>
	Occasional Mass Mailing	<u>1</u>
	Christmas Newsletter	<u>1</u>

The majority indicated that they send personal letters to families in response to inquiries or when the retardate becomes ill, injured or there is a drastic change in his condition or change in his program. Other general mailings are indicated by the comments below:

- "Monthly billings, requests for income tax information, monthly school paper during school term. "
- "Occasional mass mailing; for example, to encourage Christmas vacations."
- "Church bulletin usually has newsletter on back to be sent to family. Occasional form letters. "
- "We have a routine check of parental visits, writing those who do not visit regularly."

3. In what specific ways do you keep in touch with parents of residents ?

The ways in which the institutions maintain family contacts are too numerous to list in detail; here, however, are direct comments which cover in general the efforts which are made to keep in touch with the family:

- "Professional staff work weekends so that they may be available when parents most frequently visit."
- "Social workers and field service workers make regular trips over the State for visits with the parents."
- "Parents have use of summer camp for picnic area during summer months. Parents and friends hold annual recognition program for staff; sponsor, jointly with the school, a May Day program; have their own summer picnic for the children and staff. Parents are encouraged to attend the Christmas Festival, graduation and other special programs."
- "Physicians, social workers, and cottage administrators are in contact with the families whenever a situation arises in which this is deemed advisable. All effort is made to encourage continuing family responsibility toward a resident except for the occasional case where such contact is therapeutically contra indicated . "
- "In emergencies we reach parents by phone, wire, or if traveling, by state police, county sheriffs, etc. Most parents let us know where they will be available or how they can be reached for emergencies."

### III. DISCUSSION

#### Commitment Laws

Good pre-admission services and procedures lead to a better maintenance of family-resident-institution relationship and it follows quite logically that maintaining the family tie is imperative if the resident is to be returned to his family after a period of training. It is, therefore, somewhat shocking to discover that there are still those in administrative positions who altogether prefer legal commitments in contrast to voluntary admissions. Even though they are in the decided minority (17 administrators preferring legal commitment against 63 preferring either legal commitment or voluntary admission; q. 1b.) concepts such as this are still prone to have their effect in discouraging the achievement of a warm and secure relationship with the individual families of the retarded.

Dr. Gunnar Dybwad, Executive Director of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN, commented as follows on this subject:

"The overwhelming opinion of NARC leadership is that admission to institutions for the retarded should be a matter of commitment only if the force of the State is required to overcome objections of the family of the retarded or of the mentally retarded person himself; otherwise, the question of admission to these institutions should be removed from any court and particularly from probation departments."

Replies to the questionnaire indicated a significant number of times that when traces of "legal stigma" were removed from the picture, parents are more likely to feel that they are still a vital and necessary part of the child's life. When this is true, parents will be more concerned and interested in planning with the institutional staff members for the resident's future welfare — regardless of whether the retardate remains at the institution permanently or returns to his home at a later time.

It is equally disconcerting to discover that a large number of those who serve on legal commissions to determine if an individual should be admitted to an institution for the retarded are considered to be rarely if at all knowledgeable in the field of mental retardation. The fact was emphasized repeatedly in the questionnaires that these individuals seldom, if ever, have an accurate knowledge of the current community facilities available to the retarded or any comprehension of the psychological and social factors involved. Based on

these facts, one can quite logically conclude that perhaps large numbers of individuals have been legally committed to institutions for the retarded who may have had their needs more ably and more economically met elsewhere .

### Diagnostic and Counselling Services

In comparing the results of this survey on pre-admission procedures with a similar study which was made by NARC in 1956,<sup>1</sup> it becomes evident that a greater understanding of the needs of parents exists than did a decade ago. Even so, the observations made on the questions concerning pre-admission counselling indicated that very little supportive help is available to parents in preparing them, as well as the retarded individual, for the inevitable shock and grief which normally accompanies the separation of a child from his family unit. It would seem that the knowledge and skills relative to separation which have been gained by case workers in other child placing agencies might well be utilized by those agencies dealing with the mentally retarded both on a State and community level. Numerous statements contained in the questionnaires indicated a definite need for closer cooperation between the institutions themselves and the community facilities, in order that each might understand more clearly the obligations as well as the limitations of the other. Helen R. Hagen has interpreted the need for and importance of effective inter-agency cooperation. She states:<sup>2</sup>

"It is the responsibility of a referring agency, whether public or private, to know exactly what services an institution provides before requesting the admission of any child. It is not enough to learn this through written intake policies or a pretty brochure about the institutional program. Referring agencies themselves must know what constitutes good institutional care. Then they must determine by actual visits to the institution, by discussion with the institutional staff, by observation of the program and services if it is a program that can help the children for whom they believe group care is needed."

After careful analysis of problems presented by both the institution

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1. Responsibility for Costs of Maintenance and Training in Public Institutions for the Mentally Retarded. National Association for Retarded Children, 1958.
  2. Hagen, Helen R. Child Care Institutions in Relationship to Other Agencies. Child Welfare League of America, New York: 1955.



and other community agencies, Miss Hagen summarizes: "The goal toward which we must work is that each child will have available to him the type of service most appropriate to him when he needs it. " Since no one agency alone can do the total welfare job "... we must trust one another and develop mutual respect for the different contribution each can make. Instead of concentrating on the weaknesses of the other agency's program, our first responsibility is to identify the unmet needs in the total community services for children and join together to get the necessary public support and understanding to overcome them."

Many of the ideas set forth here would be of value to staff members of all residential schools for the retarded as well as for all community agencies serving the retarded. In commenting on the need for closer cooperation between all agencies serving the retarded, one administrator made this timely and pertinent observation: "Too many of our State institutions are 'closed shops'. They pay little attention to community services for the retarded, they pay little attention to public school classes, they pay little attention to parent groups, and they even pay little attention to other State institutions. Each of us can learn something from the other fellow,"<sup>3</sup>

It is important to note that approximately one-third of our institutions (q. 2c.) still provide no orientation program for parents and apparently make little, if any effort to involve the parents in any long-range planning for the child's future. Within the past decade a substantial number of residential centers have developed a handbook for parents interpreting the policies of the center as well as answering many of the routine questions that parents ask. This is considered to be a step in the right direction and those institutions making such provisions are to be highly commended. It should be emphasized, however, that a handbook, no matter how good, can never take the place of the warm and understanding personal counselling which a parent needs at this time.

#### Waiting Period for Admission

Answers to this section of the questionnaire revealed that parents with children on a waiting list for a State institution for the retarded are frequently left in a "no man's land" as far as counselling and help are concerned. In many cases the institutions indicated that they could assume

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3. Ray, David B., Jr. Changing Concepts in State Institutions for Retarded Children, Workshop on Residential Care of the Retarded, 1960 Annual Convention, NARC.

no responsibility for giving help to parents until the actual admission of the retardate into the institution. On the other hand, it is a well known fact that community agencies frequently feel that their responsibility is at an end once the individual is placed on a waiting list for a State institution. According to the data from the questionnaires, there was a total of 25,939 individuals on waiting lists for institutions for the retarded. The great majority of institutions had waiting lists numbering up to 500. Approximately one-third of the institutions returning the questionnaire indicated their average waiting period lasted from one to two years; 16 institutions indicated their average waiting period of three to four years. These figures indicate clearly the enormity of the problem that exists, because not only are the retarded individuals themselves affected but all of their family members as well. 24 institutions indicated they had no help at all for parents during the interim period; those indicating they provided some help emphasized that the assistance they could give was very limited due to a lack of personnel. Only about half (q. 3e.) made regular use of the resources available from the Association for Retarded Children.

#### Maintaining Family-Resident Relationships

Data from this section of the questionnaire revealed a fairly hopeful trend. 27 institutions indicated that family members were permitted to visit residents anytime after admission; 4 indicated a one week period before visits were permitted, and 12 a two week period. A careful study of additional material other than the data from the questionnaires themselves revealed the fact that a substantial number of workers in the field of mental retardation believe that a more intensive effort must be put forth on the part of institutional personnel in helping to keep the family ties strong and unbroken. The following excerpts from several articles published in professional journals and magazines tend to corroborate many of the ideas and views concerning institutional care which members of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN have advocated for a number of years.

"Many hospitals have rigid restrictions against visitors for the first ten days after admission, and this is believed by some to be a strong contributory factor toward breaking of family ties. This is a case of 'out of sight, out of mind so to speak. Nurses and physicians were cited as the two groups most resistant to un-restricted visiting. Further, it was pointed out that many hospitals schedule their visiting days or hours at the very times when physicians

are not available, and so the relatives never get a chance to talk to their patient's doctor. One hospital has solved this by setting aside one hour daily when all staff physicians are available to visitors. The admission interview can actually set the tone for the patient-family relationship during the entire period of hospitalization. " <sup>4</sup>

"Next to telephones and typewriters, two cameras are the most frequently used pieces of office equipment in our hospital. One of these is a Polaroid model which our office personnel quickly became as adept at operating as they are at typing, transcribing and filing. It is used almost daily in answer to requests from patients to have a picture to send home, or from families for a pictorial report on how their loved one is doing. New patients are routinely photographed shortly after admission and the picture is sent to the family with the first letter from the medical director as added assurance that the patient arrived safely and is adjusting comfortably." <sup>5</sup>

"Now when the custodial attitude is making way rapidly for the dynamic approach to the problems of treatment and training of mental defectives, it is time for the parents to be uniformly recognized by the hospitals as members of the therapeutic team. . . The admission of the patient into an institution does not automatically lessen the parents' need for help and support because nearly all problems, complexes, and doubts are liable to be re-activated immediately after separation; if they are not handled skillfully at this stage, they may remain as the basis of parental withdrawal or aggressiveness. It is obvious, therefore, that the training program in hospitals should preserve the parent-child relationship as much as possible... The old procedure of admission under the Mental Deficiency Acts, which was very much like a criminal procedure, made the

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4. Cleland, R.A. and Pepper, Peter A. "The Patient's Social Community - Maintaining Contact" Mental Hospitals, Vol. 12, No. 2, Feb., 1961.
  5. Kesnan, Betty. "Keep the Family in the Picture" Mental Hospitals, Vol. 12, No. 2, Feb., 1961.

majority of parents feel ashamed and guilty and therefore in special need of re-assurance and support at this time . . . They should be given every opportunity to see the hospital and should be encouraged to ask questions in order to air their emotions and dispel their doubts. The routine of hospital life, training, recreations, and legal aspects, as well as their rights as parents should be explained to them. It must also be made perfectly clear that the hospital staff will maintain the link with home and become 'agents' of the family, but will never try to replace the family as a vital centre of the patient's life.. It must be stressed time and again that parents are the key people in the patient's life and that the hospital staff cannot and will not be their substitute as the close link with home is one of the most vital forces in determining progress. " <sup>6</sup>

In commenting on the changing concepts of institutional care, Dr, Laura L. Dittman, U.S. Children's Bureau, made these pertinent observations in regard to making the family a more vital part of the total effort in behalf of the retardate:

"The family, therefore, has to be ready to let the child go, and at the same time, be willing to assume a receiving posture again... These factors influence the thinking of the family, and pose new problems for the staff of the institution as well. We must recognize their existence before we can answer questions such as : 'What can parents expect from the institution? What does the institution expect from them?' Parents and institution staff profess that they want a closer relationship. Parents, daring now for the first time to assume that they have rights and duties and that their children have rights, want to know the truth about the institution — its problems, its strong points, its 'skeletons', its triumphs. The parents want to know the reasons behind its policies and procedures. Some are traditions, hoary with age. These need review in the light of

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6. Wallen, W. "The Parental Role in the Care and Training of Mental Defectives" Mental Health, Vol. IX, No. 4, Winter, 1961. (National Association for Mental Health, London, England.)

modern practices and philosophy. Some are for the convenience of staff, not necessarily for the good of child or parent. Some suit one kind of child and not another., The policies regulating visiting hours may be one area where tradition has interfered with, not cemented, closer relationships, " <sup>7</sup>

#### Transfer of Institutionalized Retardates from State to State\*

Another very serious problem faced by an increasingly large percentage of families with retarded children is the problem of obtaining residential care for their retarded child when having moved from one State to another. This has become an acute problem within the past decade due to these two factors over which the families involved have little control:

- a. The rapidly expanding trend toward de-centralization of industrial plants which require fairly frequent moves for key management personnel and skilled workmen.
- b. The increasingly large number of families serving in all branches of the armed forces. This problem is exceedingly acute for many members of armed personnel overseas.

The rigidity of many State laws in reference to residence requirements creates a situation which so complicates the problem for these families that many of them simply give up on any attempt to move their institutionalized retarded child into their State of current residence. This is not only detrimental to the welfare of the child but to the family unit as well.

In 1955 a number of State officials from a group of the north-eastern States, recognizing the seriousness of this problem and taking into consideration the humanitarian issues involved, joined together to make a study of some possible solution to the problem. Their study and planning subsequently

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7. Dittman, Laura L. "The Family of the Child in an Institution" American Journal of Mental Deficiency, Vol. 66, No. 5, March, 1962. (Reprint available from NARC.)

\* Note: This subject was not included in the questionnaire, but voluminous correspondence from parents and institution personnel encountering this problem prompted the Committee to include its consideration in this report.

resulted in the now well-known "Interstate Compact on Mental Health". Within a few years after the enactment of the original Compact, a number of other States became members of the Compact in order to provide more adequate service for the mentally ill and mentally retarded of their State. The purposes of the Compact are:

1. "To assure that any party State will give care and treatment to any person found in that State who is in need of institutionalization by reason of mental illness or mental deficiency;
2. To permit the transfer of such a patient to an institution in another State when clinical determinations indicate that such a transfer would be in the best interest of the patient;
3. To provide interstate cooperative machinery for after-care or supervision of patients in convalescent status or conditional release;
4. To authorize additional supplementary agreements between party States 'for the provision of any service or facility or for the maintenance of any institution on a joint or cooperative basis' when any two or more States wish to do so.<sup>8</sup>

To date, twenty-eight States have signed the Compact. According to a compilation of comments and data which was prepared for a meeting of the Compact Administrators in May, 1961, the States participating had only praise to offer for the effectiveness of the Compact in cutting through the traditional legal red tape in order to provide more effective service to the retarded and mentally ill who were moved from one State to another.

The NARC Committee on Residential Care believes that the Interstate Compact on Mental Health is of fundamental importance to significant numbers of parents with institutionalized retarded children. Careful and serious consideration by appropriate State agencies toward belonging to the Compact is warranted.

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8. Council of State Governments. Interstate Compact on Mental Health, Rev. June 1962. (1313 East 60th St., Chicago, Illinois)

#### IV. CONCLUDING REMARKS

Based on the data obtained from the questionnaires as well as several years study of current professional literature relating to residential care, the NARC Committee on Residential Care arrived at these several conclusions:

- Sentiment for volunteer admissions rather than legal commitment appears to be growing in administrative circles and it may be possible that within the next decade all traces of so called "legal stigma " will be entirely removed from the process of placing a retarded child in residential care.
- A great deal remains to be done in the area of providing more adequate diagnostic and counselling services for families who are considering the possibility of residential care for a retarded child.
- There is a dire need for a closer working liaison between the staff members of institutions and the community agencies serving the retarded. This would help to fill the need of those parents (some 25 thousand plus) who have children on the waiting lists for institutions, many of whom are now devoid of any professional counselling service during this critical period.
- A more intensive effort should be made by all institutions to maintain strong family ties for the benefit of both the resident and his family.

With the changing concepts in State residential centers for the retarded, planning toward smaller, more strategically located centers in the State; with more clinics to diagnose, evaluate and counsel with families of the retarded; with increased community services available for education and training and with the added emphasis on rehabilitation of those already in residential care, there is a growing hope that residential centers for the retarded will no longer be considered as a "last resort". Rather, it is to be expected that residential care will be chosen because it best meets the needs of an individual retardate at a specific phase of his life span. This continuum of care concept Which emphasizes the need for a broad spectrum of services for the retarded will no doubt be the means of helping the residential center to more nearly achieve its major purposes and goals.

## V, RECOMMENDATIONS

1. Voluntary admission should be the primary means for securing residential care, with court commitments provided for only in cases where necessary for the welfare of the retardate.
2. When a court commitment is considered, the court should be supplied with a comprehensive diagnostic evaluation by professionally qualified persons in medicine, education, social work and psychology.
3. Sufficient and adequate diagnostic, evaluation, and counselling services should be provided to help parents determine whether institutionalization is necessary. Counsellors should be aware of all community and State facilities for the retarded and member units of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN to which families may be referred.
4. Improved and expanded pre-admission and orientation services should be developed to serve the retardate and family prior to admission. Parents should be required in most cases to visit the institution prior to admission.
5. Every effort should be made for close cooperation and communication between community agencies and the institution.
6. Each State residential center should have a printed reference booklet to give parents for reference. Also, more emphasis should be placed on interpreting policies, routines, schedules, etc., on a personal basis.
7. All institutions should have an "open door policy" permitting parents to visit and observe any time after admission.
8. More emphasis should be placed on communication with families through regular newsletters, open house, parent meetings at the institution, routine correspondence, etc.
9. Frequent home visits by the retarded should be encouraged; in addition, parents should be encouraged to write their children and retardates should be helped to write their parents as often as possible. These communications should not be censored.
10. States should be encouraged to join the Interstate Compact on Mental Health in order to facilitate movement of institutionalized retarded children from one State to another.



## VI. REFERENCES

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3. Ray, David B. , Jr. Changing Concepts in State Institutions for Retarded Children. Workshop on Residential Care of the Retarded, 1960 Annual Convention, NARC
4. Cleland, R.A. and Peffer, Peter A. "The Patient's Social Community-Maintaining Contact" Mental Hospitals, Vol. 12, No. 2, Feb., 1961.
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7. Dittman, Laura L. "The Family of the Child in an Institution" American Journal of Mental Deficiency, Vol. 66, No. 5, March, 1962. (Reprint available from NARC.)
8. Council of State Governments. Interstate Compact on Mental Health, Rev. June 1962. (1313 East 60th St., Chicago, Illinois)

A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED IN  
THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

PART III. FOOD SERVICES

## I. INTRODUCTION

In assuming the care of an individual the institution assumes the responsibility for the development, well being, and in fact, provision of the basic needs of that individual, whether it be for shelter, clothing, or for food and nourishment. In most States, statutes relative to residential care of the mentally retarded spell out these responsibilities, and where not stated they are implied.

Food is important to the life of the mentally retarded person living in the institution. It is essential to the very survival of the individual. It provides the nutritional resources for healthy growth and development. Food has psychological meaning to the person, and it furthermore enhances the life of the individual through the pleasurable aspects of eating. It was for these reasons that the NARC Committee on Residential Care included a section on food services as an important part of the total survey.

Data was collected by use of a questionnaire sent to 111 State-supported institutions for the mentally retarded, of which 80 responded. This data was analyzed by a professional consultant on food services for large numbers of people. In addition, the literature on food services in child caring institutions and mental hospitals was reviewed for its relevance to food services in residential facilities for the mentally retarded. It is the intention of this section to review current practices, to lift up major issues and make recommendations which will bring into focus the dietary needs of the mentally retarded persons living in the institutions,

## II. DATA FROM FOOD SERVICE QUESTIONNAIRE

Data for institutional food services covered staffing, physical facilities, costs, calorie intake and types of recipes.

1. Median ratio of employee food service workers to residents 1:34

Median ratio of resident (trainee) food service workers to residents 1:24.5

Number of institutions having dieticians	1 or more	57
	None	23

Six institutions reported an employee food service worker to resident food service worker ratio ranging from 1:102 to 1:154. The few exclusively central food services reported the average ratio of 1:8. Seven institutions reported that no residents worked in food service areas.

2.a. Method of food preparation and service:

Central feeding	4
Individual cottages	7
Central community with cottage dining rooms	69

Truck	7
Conveyor	3
Electric Carts	25
Carts	12
Carvold	19
Other	1

Most institutions use a central commissary to prepare food and haul it in some type of heat insulated container or cart, where it is quickly served without reheating. Many institutions use a combination of methods of transporting food. Only four of those reporting use insulated containers for hot foods.

- b. What distance is food moved ? Nearest? Farthest?

The response to this question was so varied that a meaningful statistical plotting of the data was not possible. Distance for movement of food ranged from as little as 25 feet up to 7 miles. A large number had to move food at least from 400 to 800 yards.

- c. QUESTION

Is food reheated in serving kitchens?	Yes	<u>26%</u>
	No	<u>64%</u>
	No answer	<u>10%</u>
Steam	Yes	<u>37%</u>
	No	<u>50%</u>
	No answer	<u>13%</u>

- d. QUESTION

Dishes, trays, tableware used by those able to feed themselves	Plastic	<u>50</u>
	Metal	<u>5</u>
	Plastic & Metal	<u>20</u>
	Plastic, metal & ceramic	<u>3</u>
	Plastic & ceramic	<u>1</u>
	No answer	<u>1</u>

The trend is to the use of plastic eating utensils, however, there are 5 institutions using metalware exclusively while some others still use metal in certain cottages. Only 4 institutions made use of ceramic ware. 27% report the use of metal cups. 16% use no knives and 14% no forks.

- e. QUESTION

Are special utensils or feeding innovations use for those residents confined to their wards ?	Yes	<u>28</u>
	No	<u>42</u>
	No answer	<u>10</u>

Only a little over 1/3 of the institutions use special devices for feeding residents with feeding problems. Most who did confined their efforts to use of spout cups.

- f. To what mental age are pureed foods served? To what mental age are foods cut by attendants ?

The answer to these two questions varied so greatly that it was impossible to report the results. Pureed foods were served to residents of all chronological ages.

3. a. QUESTION

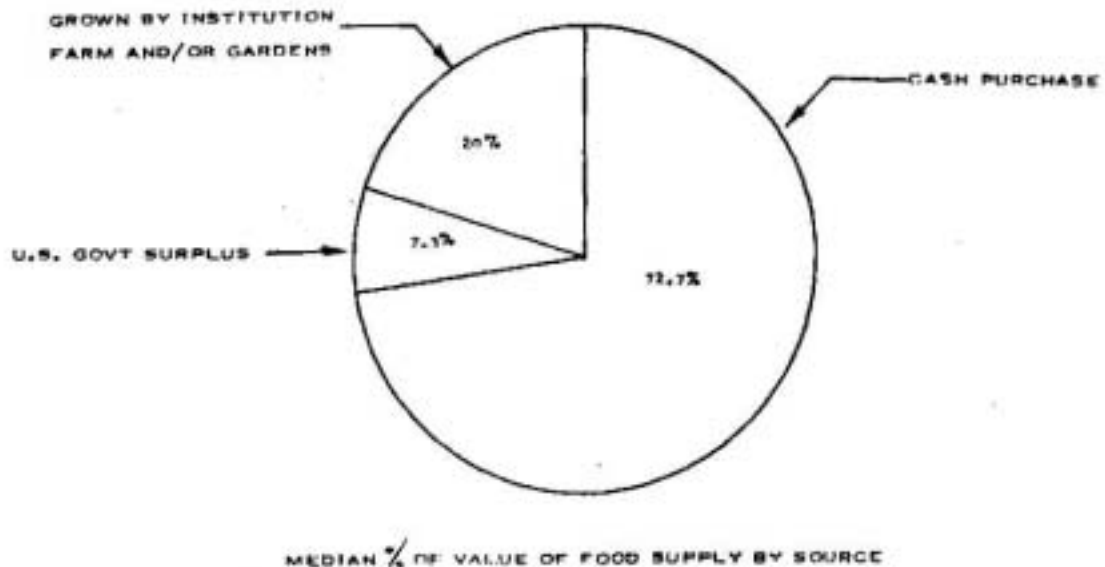
Average cost of daily food	Far Western States
ration per resident	Rest of the country

69¢

61¢

One institution reported a per resident food ratio of **12¢** per day, while another reported **26¢**. The lowest per diem food allowance which seemed valid was **40¢**. One institution which had its food catered reported a per resident cost of \$1.07 per day.

- b.



The 20% figure applies only to institutions which raise a part of their food needs. 39% of those reporting raised no food at all. Of those who did, the figure ranged from less than 17% to 60% of the food needs. Several institutions (6.7%) made no use of U.S. Government Surplus, while many institutions used this source for as high as 10% to 25% of their food costs.

4.a.

<u>QUESTION</u>	<u>AGE RANGE</u>	<u>AVERAGE CALORIE INTAKE</u>
What calorie intakes per day are provided for in these age groups?	1-6	1500 - 1900
	6-12	2400 - 2500
	12-up	3000

There was little consistency in caloric value provided for the various age groups. For example, 6-12 year olds were provided with as little as 1200 calories per day, and as much as 4000. Only a few of the institutions differentiated between the requirements of males and females or made note of a procedure to provide the nutrients according to the individual needs of the resident.

b.

<u>QUESTION</u>		
Are food supplements used?	Yes	<u>61%</u>
	No	<u>33%</u>
	No answer	<u>6 %</u>

c.

<u>QUESTION</u>		
Are vitamin supplements used?	Yes	<u>76%</u>
	No	<u>18%</u>
	No answer	<u>6%</u>

Although almost 2/3 of the institutions reported use of food supplements and 3/4 reported use of vitamin supplements, the remarks indicated that their usage was extremely limited.

5.a. QUESTION

Are standard receipes used ?	Yes	<u>75</u>
	No	<u>5</u>

b. QUESTION

Is a master menu used for the State ?	Yes	<u>12</u>
	No	<u>65</u>
	No answer	<u>3</u>

c. QUESTION

Are cycle menus used ?	Yes	<u>6</u>
	No	<u>42</u>
	No answer	<u>2</u>

The trend is overwhelmingly to use of standard recipes, with about 45% of the institutions using cycle menus. Menus are set for the institution by State Central Offices in a very few States.

6, List in order of importance your greatest needs in providing more adequate meals:

- |                                |   |                 |
|--------------------------------|---|-----------------|
| a. More modern equipment       | 2 | (Ranked by In-  |
| b. Larger daily food allowance | 3 | stitutions res- |
| c. More staff                  | 1 | ponding)        |

In separate questions the institutions were asked to name major problems in food preparation and serving areas. For the most part, problems were equated with the above needs, with half of the institutions reporting that their major problem was that of small, under-trained food service staff, while the number two problem was that of poorly-designed, ill-equipped food service facilities. The feeding of children with severe swallowing difficulties was an additional problem.



7. The questionnaire requested additional information on innovations in preparation or serving food. The following is a limited list of some of the more interesting responses:
- A garbage disposal unit on a portable stand is used to puree food; sanitizing procedures approved by Health Dept.
  - Serve at table for four on plastic dishware.
  - Working residents eat in employee cafeteria.
  - Diet trays made attractive as possible.
  - Cafeteria style food service, tables for four, resident sits where he chooses.
  - Meat cut for portion control.
  - Family style serving.
  - "For learners we use 1" cubed meat".
  - Breakfast entrees prepared at service center for hot, better flavored breakfasts.
  - High protein, high fruit diets with minimum fats for inactive residents with swallowing problem, heart used to supplement beef for iron content. Soups thick like puddings, breakfast cereals cooked with added dry milk solids, fresh eggs and butter.

### III

## DISCUSSION

### Personnel

Almost one-third of the institutions had no trained dietitian on their staffs. This lack was reflected in faulty or missing information on caloric intake and need for dietary supplements. On the other hand, where institutions had dieticians, most of the caloric provisions were reasonable and there was evidence of proper administration of needed diet supplements.

The problem named most was the need for a sufficient number of adequately trained food service staff. The average ratio of paid food service workers was about 1 to 34. Where individual cottage-type kitchens were utilized, the ratio was about 1 to 20, while the few exclusively central food services were over-staffed at the average ratio of approximately 1 to 8.

It was surprising, yet gratifying, to learn that there is little adherence to the old institution credo of reducing paid food service workers and replacing them with resident food service workers. The supply of resident workers seemed to be directly related to the supply of paid food service workers.

The problem of personnel is described as "too few, unskilled and short tenure!" The main reason for these conditions is that of low pay. Good cooks are highly skilled technicians, and usually ply their trade under rather unpleasant working conditions. Where this is not compensated by commensurate salary, these most necessary craftsmen drift into higher pay situations, leaving the institution with the less competent who will work for the offered pay.

While there is no substitute for good managers and cooks, some of the effects of their short supply can be overcome by using the few good people one has to the best advantage (grouping the tasks demanding skill around the man having the skill), and using foodstuffs with built-in application of skill (pre-cooked, frozen and ready prepared items), or equipment that automatically performs most of the cooking tasks (automatic pressure cookers, oven controls, kettle controls, basket lift-out devices for fryers, proper type mixers in kettles, refrigerated kettles, Schnell cutters, etc.).

### Types of Feeding Systems

#### Domicile

The domicile type of system providing individual kitchens in each cottage, under optimum conditions should be capable of turning out the highest quality food as it can be prepared close to the serving time and without having to be transported. Every minute that prepared food must wait prior to being served and every foot it must be transported detracts from its quality.

While this advantage, together with that of being able to cater easily to the individual needs of the cottage residents, appears to load the scale in favor of this type of feeding, there are a number of opposing factors that must be borne in mind. A few of these are:

1. Individual kitchens mean duplication of all necessary equipment, much of which is used but a small portion of the time in the individual kitchen. This means that individual kitchens cost more to build per resident fed. Also, because of the small size of the kitchen, it usually is not feasible to include much of the labor saving equipment that increases the productivity of workers in the efficient large kitchen.

2. It is quite difficult to acquire enough good cooks for the small salaries that can be paid for personnel in a small kitchen. In the large kitchen one should be able to pay for a few top-notch cooks, or even if premium salaries cannot be offered, one should be able to acquire a few good personnel by chance. By judicious placement of these good people one can leaven up the quality of the entire operation. In the small kitchen if one cook is good the cottage food is good, but if he is mediocre, all the food is mediocre. Also, if by chance one does have a good cottage cook, what happens when he has worked his five days, is sick or on vacation? In the large operation one can redistribute other good people to cover the critical gaps, but in the cottage operation there is usually no substitute of equal competency to take over. At least one institution has covered this eventuality by having a number of unassigned and adaptable cooks and assistants in a pool. Others have part-time people that they can call in when needed.

#### Central Feeding

"Central feeding" conducted with cafeteria style service is the least expensive method of feeding, and can provide high quality food. It has

worked out this way in industrial and commercial feeding, and should respond similarly in the institutions if the feeding facilities are properly designed and the operations are conducted efficiently. It should be noted that the average cost of this method in this system was  $\frac{2}{3}$  of 1¢ higher per diem than the initial average.

Central feeding allows for the preparation of food as it is needed on the serving line, and in no greater quantities than those necessary to feed the last resident who passes through the serving line. It allows utilization of the most skilled cooks and allows the relegation of the low skilled or incompetent cook to the routine or repetitive tasks. Also, certain of the personnel who work on the early stages of the food preparation are available to perform the service in the cafeteria lines and carry out the dishwashing duties. Then, when illness or other absence take key personnel, the large kitchen operation has qualified people to move in as substitutes.

Preparation in quantity makes it feasible to use most of the labor saving and food saving equipment that the small cottage or dormitory kitchen cannot afford. This enables greater food production per worker and square foot of floor space. The main problem encountered in use of this system is the movement of residents between the cottages and the central food service facility.

#### Central Food Preparation and Domicile Service

As the greater number of the institutions find it expedient to feed most of their residents in the dormitories or cottages due to lack of mobility of the severely retarded children or difficulties in taking them out in inclement weather, and because in-domicile cooking is too expensive, they use central food preparation and some form of transport to carry the food from kitchen to residence.

While in the past food has been hauled in uninsulated cans and pans on open carts or trucks, now most institutions use either insulated carts (that might be heated or not) or insulate hand-carried containers. Whereby in the uninsulated cans often the food had to be served lukewarm or had to be reheated before serving, in the insulated hand-carried containers. Whereby served hot without further heating. Methods that depend on insulation are preferred to those that require reheating as they do not usually damage the food quality quite as much. Similarly, food that can be served directly from the transport container will be better in quality than that transferred into a steam table pan.

There seems to be a growing trend toward using insulated carts for transport, as the hand-carried containers are bulky and heavy. In some cases the carts are moved by manpower. Some are pulled by tractors, some are self-powered, but most are carried in trucks where they can be lowered to ground level by means of powered tailgates or run at truck body height directly into the commissary and the domicile. A few of the insulated conveyors have both hot and cold sections, some are merely heated and the rest have only the insulation to keep the food properly heated or cooled.

There is no one best type of conveyor as each has a use under certain circumstances, although insulation is desirable in most cases. In small areas and level passageways hand-pushed carts go well, but where the distances increase somewhat, self-powered and tractor-powered conveyors and conveyor trains become desirable. Where transport distances are long the conveyors have to be transported in trucks or they wear out too soon.

Where distances are long, heated carts are desirable. This may be done by pre-heating the carts with heated storage rooms, plug-in electric heaters, heated discs or hot stones. The loaded carts with electric units can be plugged in when they get to the point of use and thus serve as hot serving carts. The others must rely on their residual heat.

### Food Preparation

While it is impossible to cover in detail the essentials of good service design, the following are criteria that cannot be ignored if operating efficiency is to be obtained:

1. Sizes and numbers of equipment must be determined by careful analysis of menus and recipes. No more equipment should be provided than is absolutely necessary for the usual operation. Too little or under-capacity equipment frequently requires undesirable splitting of batches. Too large equipment causes heat and food material to be lost, makes it difficult to properly prepare the product and increases cleaning time; too much equipment increases distances that cooks must travel to circumvent unused equipment,
2. Equipment should be arranged as near as possible in a straight line from receiving to storage to preparation to cookery to service. If the shape of the kitchen forbids straightline, the arrangement of equipment should allow a minimum of cross traffic. Most used combinations of

equipment should be located close together and in the order of most frequent inter-use from storage to service. Where a piece of equipment is used in more than one production series it should be placed in the line where used most or half-way between two production areas if used equally in both.

3. Equipment should be arranged at right angles to the serving line with frequent spaces for passthrough of personnel.

4. Every effort should be made to handle the food material at waist height with a minimum of human lifting. All walk-in refrigerators should have doorsills flush with the floor to permit moving the food material in and out on the wheeled shelving. Food movement distances should be minimal from receiving to service.

5. In so far as possible, cooking and preparation should be automatically controlled with mechanical or electronic devices to do the stirring, measuring and tending.

6. Work table space should be available beside each fryer, griddle, or range and preferably closely in front of the ovens. Racks or portable tables should be available on or close to the steam-jacketed kettles. These surfaces are for the raw and cooked material, spices and holding serving utensils. It is dangerous, wasteful of food material and inefficient labor utilization to force a cook to work back and forth across aisles. At the same time, aisle widths should be minimal to reduce wasteful movement of the cooks.

7. All tasks demanding skill should be grouped around the cooks having the skill. All resident food service workers who are not trained to the skill equivalency of cooks should be kept out of the cooking areas during food preparation so that cooks can apply their full skill to preparation of appetizing food, rather than dilute their effectiveness by constant direction of unskilled personnel. If it is desired to use resident food service personnel it should be in diningroom, dishwashing and vegetable preparation areas under the supervision of attendants rather than cooks. Using unskilled men in cookery even under the supervision of skilled cooks greatly lowers the quality of the finished food.

### Food Costs

One of the greatest needs listed by Institutions was for increased food allowance. Based on analysis of numerous menus it is felt that by efficient food service management and intelligent purchasing the average institution east of the Rocky Mountains should be able to serve nutritionally adequate and aesthetically attractive meals at a raw food cost of about \$.68 per resident per day. West of the Rocky Mountains will be about \$.05 more and institutions where the food is purchased locally or where the population is predominantly working adults, the cost will be about \$.78 per resident per day for the unprepared food.

Traditionally, institution farms, dairies and gardens have been thought to be a major source of supplementing food costs for those institutions. Although the trend seems to be away from this source (39% of those reporting raised no food (q. 3b.)), those who did relied on this source for up to 60% of their food costs with the median being 20%. Some Institutions have made cost analyses of farm operation and found that what appears to be a source of saving in food costs has in reality been unprofitable. One western State with relatively small populations in each of its institutions has developed a central dairy which is reported to profitably supply milk to several institutions. Dieticians and food service managers find themselves unable to plan balanced menus when gardens are a major source of fresh vegetables. If the crop is good, residents are subjected to a monotonous diet of the same food for several days, or even weeks at a time.

Another supplementary source for food cost of significance is U.S. Government Surplus. This source accounts for up to 10% - 25% of food costs for some institutions. The median is 7.3 % (q. 3b.). This important resource is either being overlooked, or for some unnamed reason is not being used by about 7% of the Institutions reporting.

### Food Quality and Service

Palatable food served in an attractive manner can add so much to the life of the person in the residential center. This is even more true if the dining room is pleasant, and residents are given ample time to leisurely enjoy the meal and the camaraderie resulting from being able to choose one's seat at a table for four. One institution has developed cafeterias where severely and moderately retarded residents choose entrees, select the tables at which they eat, and their companions on a co-educational basis. Physically handicapped persons go through the line if at all possible, and when not able, a friend carries their trays.

Evidence from the survey indicates that attention to the nutritional needs leaves much to be desired (see questions on caloric intake and food and vitamin supplements). The fact that the mentally retarded need every opportunity to enhance development requires attention to this important factor.

The overwhelming use of standard recipes should contribute positively toward better meeting of nutritional needs. The trend toward the use of cyclic menus should also help attain a goal of providing better meals. Irving Engelman, in writing about institutional care for the aged<sup>1</sup> has pointed out, however, that "... the criteria of the written menu for determining adequacy are valueless. Foods must be evaluated in preparation, size of servings and amount eaten by the patient. " Cyclic menus offer the possibility that residents will not be eating the same things day after day, but if the cycle is too short their use could mean that they can anticipate "Beans on Monday, hominy on Tuesday, etc. "

The great number of institutionalized mentally retarded who have accompanying handicaps in chewing and swallowing has created a challenge to assist these persons in developing their abilities. The use of pureed and other semi-solid undistinguishable foods has been an expedient way of feeding severely handicapped persons en masse. The survey indicated a reliance on this expedient beyond the time when many could be developing ability to chew and swallow. An even more questionable practice of assembly line tube feeding has been observed in a small number of institutions.

Fortunately, a few specialized residential centers are leading the way in helping persons with eating problems to graduate from pureed foods to those of varying texture and on up to bite-size pieces. One such institution employs every person from the gardener to the superintendent and his secretary to help these multiply handicapped people at mealtime.

Although there is a trend to the use of plastic dishes, it is depressing to note that a few institutions still use metal utensils exclusively and that a number of others use metal cups or trays. While metal utensils have the advantage of being relatively indestructible, the disadvantage of rapid cooling of the food, difficulty of drinking hot or cold liquids from them, and the unpleasant appearance greatly outweigh the benefits derived and militate against the use of these archaic utensils.

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1. Engleman, Irving J. "Improving Institutional Care for the Aged, " The Welfare Reporter, New Jersey Department of Institutions and Agencies. Trenton: July, 1958.



#### IV. CONCLUDING REMARKS

The survey points up three major needs in food service: more adequately trained staff and better use of existing staff, particularly dieticians; more modern equipment with efficient use and arrangement of existing equipment; and increased daily food allowances. An article written in 1957 by Arthur Avery, Technical Director of the Commissary Research Division, U.S. Navy, pointed up ways to improve institutional food. These points might well have been directed to the problem areas elicited in this present survey. They are as follows: <sup>2</sup>

"First, and foremost, those people who are in authority — the superintendents, the State officialdom, and the old time food service supervisors have got to be made to realize that good food production is an exacting science requiring precise tested formulae, equipment with proper capacity and temperature and time controls, and food service personnel with both the training and incentive to raise food quality to the proper level.

Second, and of almost equal importance, is the necessity for furnishing good raw food material. Purchase specifications must be rigid, inspection must be thorough, turnover must be regulated and sub-standard food materials must not be used. A prepared food can be no better than the raw material from which it is made. Overzealous purchase of low quality food material means an overabundance of garbage. Careful consideration of quality as well as the relative as-eaten cost of fresh, canned, frozen and dehydrated foods will do more to lower food costs than will indiscriminate purchase of the cheapest, per as-purchased pound food.

Third, while it is realized that every institution cannot just junk the equipment they have and install an ultramodern setup, they can bring in progress-minded industrial and equipment engineers to draw up a master blueprint for efficient labor-saving food production and wherever possible replace inefficient old fashioned equipment with new labor and food saving equipment. Also, in some cases the addition

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2. Avery, Arthur C. "Institutional Food, " American Journal of Mental Deficiency, Vol. 62, No. 3, Nov. 1957.

of a mechanical timer, an indicating thermometer, or inexpensive automatic control will double the value of an existing piece of equipment. In other cases, minor rearrangement of existing pieces of equipment will enable our best cooks to extend their skill over a greater number of operations.

Fourth, we must stop adding the duties of attendant and student supervisor to the food production duties of the cook. While it is granted, working in the kitchen can be a training aid and that some of the retarded children perform duties that would have to be done by semi-skilled and laboring paid-workers, it is quite doubtful that the advantages outweigh the disadvantages. Not only are good cooks too scarce a commodity to waste on unnecessary supervisory work, but it has long been established that a production facility operating under pressure is not a suitable place to learn.

The children need to be taught their trade in school laboratories by teachers who are trained in instruction. If we would move all except the most highly trained personnel out of the kitchens, move the equipment around these people, and install a few labor-saving devices, the kitchen personnel could accomplish the work for which they are paid. "

## V. RECOMMENDATIONS

1. Each institution should have a trained dietician directing its food service program, with adequate numbers of trained food service staff.
2. Food budgets should be ample and flexible in order to meet changing costs.
3. Menus should offer a variety of the basic seven foods.
4. Food should be prepared as close to serving time as possible, delivered to serving area with least number of handlings, and served hot.
5. Special attention should be given to serving foods of varying textures and consistency, and persons with handicaps in chewing and swallowing should be aided in developing these skills.
6. Further detailed study of kitchen layout and equipment is needed in most institutions.
7. Dining rooms should be co-educational and offer a cheerful, leisurely atmosphere with choice of seating at tables for four. Tableware should be the same as that found in the family home.

VI.

REFERENCES

1. Engleman, Irving J. "Improving Institutional Care for the Aged, " The Welfare Reporter, New Jersey State Department of Institutions and Agencies. Trenton: July, 1958.
- 2, Avery, Arthur C. "Institutional Food, " American Journal of Mental Deficiency, Vol. 62, No. 3, Nov.1957.

A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED  
IN THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

PART IV. CLOTHING

## I. INTRODUCTION

One area of residential care which causes parents much concern and which gives rise to many complaints is in the matter of clothing for the residents. Numerous other areas of services or programs are somewhat intangible and it is difficult for parents to pin-point their grievances. In the matter of clothing and personal hygiene, however, the evidence of careful attention or careless indifference is in plain view and parents are prone to make their feelings known to those who bear the responsibility of caring for their children.

NARC chose to include the study of the clothing problem as one of the sections on the total Survey on Residential Care because of the vital importance of clothing in promoting the dignity and individuality of every human being, regardless of how limited. The purpose of the clothing study was two-fold: to obtain information which would point out the major problems involved in the management of clothing for the retarded in residential care, and, to obtain suggestions and ideas as to how some of these problems might be solved.

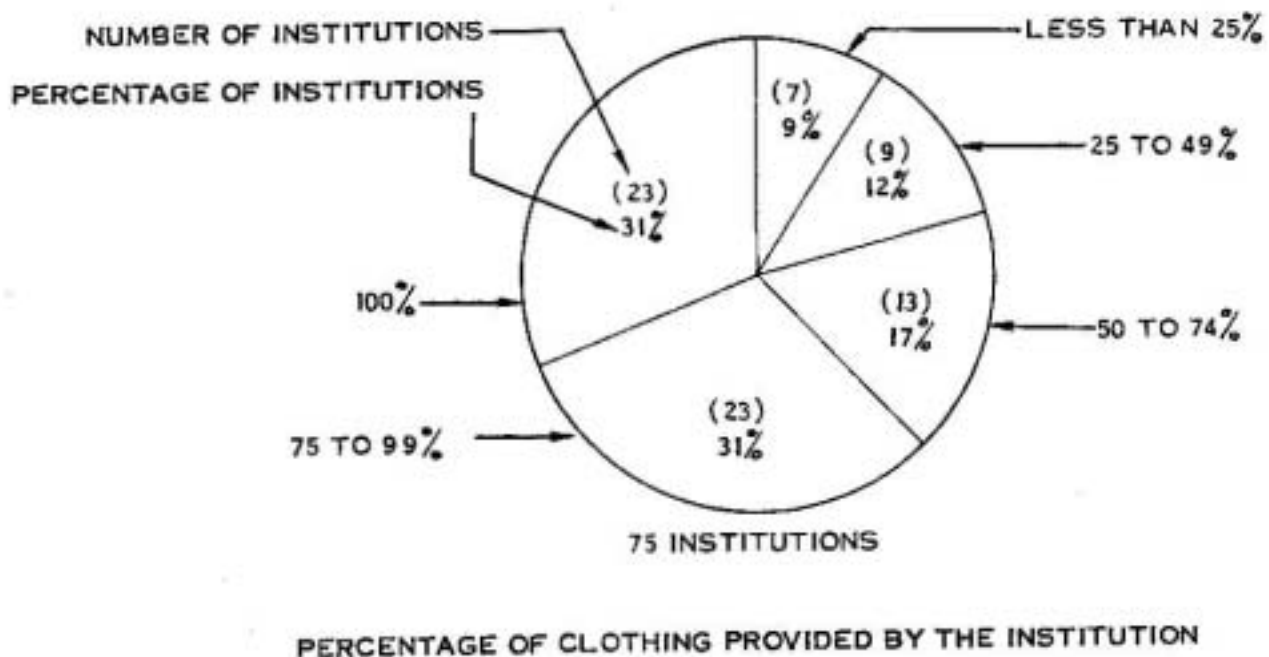
To achieve this end, a clothing questionnaire was submitted to 111 State residential centers for the retarded. The questionnaire was returned by 95 of those surveyed. Information received from these questionnaires enabled the Committee to take a candid look at some of the basic problems which appear to exist in regard to clothing the residents of institutions for the retarded. A resume of the information obtained is presented herewith. Following the presentation of the data is a discussion of the facts presented, some conclusions drawn as a result of the study, and recommendations for possible solutions to some of the problems that the study revealed.

## II. DATA FROM QUESTIONNAIRE ON CLOTHING

Presented below, with comments in some instances, are the questions and answers relating to the clothing questionnaire. For the sake of clarity the questions were divided into four specific areas: Responsibility for Provision of Clothing; Distribution, Fitting and Care of Clothing; Difficulties and Problems; The Importance of Clothing to the Retarded.

### Responsibility for Provision of Clothing 1 a.

What is your annual clothing allowance per person?



Almost one-third of those institutions reporting provide all of the clothing needs of their residents from State tax funds, and a like number provide 75% or more of the clothing needs. The highest clothing allowance was \$44.27 per resident per year, with the lowest \$13.20 and a median of \$28.73.

b. QUESTION	NO. INSTITUTIONS		c. QUESTION	NO. INSTITUTIONS	
Are you required by State law by precedent to buy from specified sources?	Yes	<u>18</u>	Do you buy on open market so as to exercise privilege of competitive bidding?	Yes	<u>76</u>
	No	<u>71</u>		No	<u>14</u>
	No ans.	<u>6</u>		No Ans.	<u>5</u>
d. QUESTION	NO. INSTITUTIONS		e. QUESTION	NO. INSTITUTIONS	
Does any part of your clothing supply come from other State institutions ?	Yes	<u>68</u>	Is good, used clothing accepted from civic clubs, service organizations?	Yes	<u>90</u>
	No	<u>26</u>		No	<u>3</u>
	No ans.	<u>1</u>		No ans.	<u>2</u> etc.

Although no comments were asked for in this section, a large number of the questionnaires contained comments on the many problems involved in securing adequate clothing for residents. Many administrators objected to the limitations placed on them in having to buy through a State Purchasing Department or its equivalent. Comments such as these were frequent:

"In State furnished areas there is the problem of having someone in a Central Purchasing area make substitutions that look like savings which can result in serious waste."



"Due to State purchasing procedures clothing needs must be anticipated almost a year in advance. This creates problems in over or under stocking. "

Frequent mention was made of the fact that their clothing budgets were quite inadequate to properly clothe all their residents. The answers received in the per deim clothing allowance (q. 1a.) give concrete support to this frequent complaint.

2.a.			b.		
<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>		<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Are parents asked to bring clothing for residents at time of admission?	Yes	<u>80</u>	Do you send a form letter indicating need for clothing?	Yes	<u>69</u>
	No	<u>13</u>		No	<u>24</u>
	No ans.	<u>22</u>		No ans.	<u>2</u>

c.			d.		
<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>		<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Are parents asked regularly to replenish the resident's wardrobe?	Yes	<u>84</u>	When parents visit if child is able, is he permitted to shop for clothing with parents ?	Yes	<u>91</u>
	No	<u>11</u>		No	<u>2</u>
	No ans.	<u>0</u>		No ans.	<u>3</u>

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Listed below are some of the limitations placed on clothing furnished by parents;

"No high heels."

"No clothes that have to be dry cleaned."

"Fabrics and designs of clothing adaptable to commercial laundering."

"Limit luxury items. Bring special clothing only when parent plans to take child 'out'."

Distribution, Fitting and Care of Clothing

- 3 .a. Please give a brief description of your clothing storage center if you have such.

According to the answers received on this question, most institutions keep their clothing in large general warehouses with one section designated for clothing storage. A limited number mentioned having storage facilities for clothing alone. The majority indicated lack of adequate space for clothing storage.

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b.			c,		
QUESTION	NO. INSTITUTIONS		QUESTION	NO. INSTITUTIONS	
Are clothes distributed at specified times during the year?	Yes <u>35</u> No <u>58</u> No ans. <u>2</u>		Are clothes distributed as needed by individuals ?	Yes <u>90</u> No <u>3</u> No ans. <u>2</u>	

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About half of the institutions polled indicated that clothing was issued at specified times, usually Spring and Fall, although a limited number indicated regular monthly distribution. All indicated that clothing was issued on an individual basis "as needed".

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d.			e.		
QUESTION	NO. INSTITUTIONS		QUESTION	NO. INSTITUTIONS	
Does the cottage parent or attendant requisition clothes for the resident?	Yes <u>82</u> No <u>8</u> No ans . <u>5</u>		Are residents ever permitted to visit storage center to make a choice in clothing ?	Yes <u>67</u> No <u>23</u> No ans. <u>5</u>	

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In the majority of cases, the cottage parent or attendant handled the requisition of clothing; in a limited number of cases this was handled by the nursing service. All institutions indicated the use of requisition forms.

Fifteen institutions reported on clothing stores in which the resident could choose his own clothing. In order to shop the resident was supplied with a requisition slip from his ward supervisor stating his needs. Many of these "stores" were operated by volunteers.

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4. a.		
QUESTION	NO. INSTITUTIONS	
Are regular checks made to insure that residents have not outgrown shoes ?	Yes	<u>90</u>
	No	<u>3</u>
	No ans.	<u>1</u>

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b.		
QUESTION	NO. INSTITUTIONS	
When clothing is outgrown is it given to another resident or is it discarded ?	Yes	
	Discarded	
	No ans.	<u>2</u>
	Returned to Family	<u>7</u>

Checks to determine shoe fittings were made by ward attendants in most cases. However, a limited number of institutions reported that this was done by nurses. A large number mentioned difficulty in fitting crippled residents.

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5.a.	QUESTION	NO. INSTITUTIONS
Do you expect cottage personnel to keep clothing separate for each resident?	Yes	<u>90</u>
	No	<u>3</u>
	No ans.	<u>2</u>

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b.		
QUESTION	NO. INSTITUTIONS	
Do your residents have one outfit for Sunday or dress-up occasions that differs from daily wear ?	Yes	<u>86</u>
	No	<u>7</u>
	No ans.	<u>2</u>

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Indication here is that the vast majority of institutions recognize the importance of keeping their residents' clothing separate. A number, however, mentioned the problems involved in this because of inadequate and poorly arranged storage space in the wards and cottages, plus the sheer numbers of residents for which most attendants were responsible.

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6. a.			b.		
QUESTION	NO. INSTITUTIONS		QUESTION	NO. INSTITUTIONS	
Do you have	Yes	<u>69</u>	Are your cottages	Yes	<u>63</u>
adequate			or wards for		
laundry	No	<u>22</u>	high-grade residents	No	<u>25</u>
facilities?	No ans.	<u>4</u>	equipped with		
			laundry facilities	No ans.	<u>7</u>
			for residents to		
			wash own clothing ?		

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Major Difficulties and Problems in Clothing Residents

7. What do you consider your most difficult problems in the area of clothing institutionalized retardates ? List in order of severity.

Although this was difficult to determine due to the variety of answers, and the ways in which they were expressed in the questionnaire, it appeared that the four most severe problems were: (in order of severity)

- a. Improper fit of clothing and shoes for physically handicapped.
- b. Destruction of clothing by tearing.
- c. Inadequate clothing budgets.
- d. Inadequate and poorly planned storage facilities in warehouses as well as in cottages and wards.

Other frequently named problems were:

- e. Laundry. Inadequate laundry facilities were listed in 22 institutions. Other laundry problems included: Variety of synthetic fabrics that cause problems; poor coordination between laundry workers and ward attendants; also mentioned several times was "how hard it is for parents to understand the additional amounts of clothing needed where laundry is central-

ly done involving changes before garments can be put in use again."

- f. Problem of obtaining attractive, serviceable clothes in a variety of colors and sizes.
- g. Lack of adequate number and adequate training of clothing personnel. Typical comments on this:  
"Many problems now existing in the clothing department could possibly be eliminated or at least simplified if the responsibility for fitting, ordering, and repairing could be placed with personnel who are trained and understand clothing, rather than the charge aide from each building carrying the responsibility."

#### The Role of Clothing in the Lives of Institutionalized Retardates

8. Do you feel that clothing plays an important role in the training of residents?

This question was answered 100% in the affirmative. The answers given as to "how" can be summed up briefly in the following representative quotations:

"Having attractive, colorful clothing makes our residents take more pride in their personal appearance."

"Attractive clothing boosts the morale of our residents — if they feel well dressed, they are happier and get along better with other residents."

"Taking care of their own clothing aids in developing personal responsibility."

"Proper clothing helps to raise self-esteem of our residents."

"Having clothing especially selected for them gives our residents a feeling of individuality; they become persons instead of numbers."

"Pride of ownership — after all, everybody wants to own something."

### III. DISCUSSION

#### Responsibility for Provision of Clothing

A number of the questionnaires stated that clothing purchases were made by persons who were not really qualified in the area of clothing selection either by training or by personal experience with the retarded in order to understand and appreciate their basic needs. Leaving the problem of clothing procurement solely in the hands of a State purchasing agency was felt to be detrimental to the welfare of the residents because those individuals responsible for such purchases seldom had a specific knowledge of the needs of the residents in an institution for the retarded. Frequent mention was made of the fact that personnel in a central purchasing agency did not take into consideration the inherent need and desire of retardates to appear as individuals rather than "enmasse". A number of administrators indicated that where a central State agency was used, greater efficiency could be achieved if the administrator or his appropriate agent were to have final approval of all purchases made.

Data from the questionnaire indicated that 18 institutions are required by State law or precedent to buy from specified sources and that 14 others are not allowed to buy on an open market in order to exercise the privilege of competitive bidding, (q. 1b.; 1c.) This data, coupled with the fact that the median annual clothing allowance per resident is only \$28.73, would indicate that economy may be the predominating factor in decisions which are made in regard to the purchase of their clothing.

#### Distribution, Fitting and Care of Clothing

Data from this section of the questionnaire indicated that in most cases (82 institutions out of 95) the cottage parent is responsible for securing appropriate clothing for the residents. Also, in 90 out of 95 institutions the ward personnel was expected to assume the responsibility for keeping the resident's clothing separated in order that each might have the pleasure of wearing his own clothing. Although the vast majority of administrators recognized the importance of keeping the clothing separated, a large number mentioned the problems involved here because of inadequate and poorly arranged storage space on the wards, plus the large number of residents for which an aide was responsible. Still seeing their children as individuals instead of one of a large number, parents are sometimes prone to overestimate how much the personnel can or should do in relation

to their resident's clothing and general appearance. On the other side of the coin, cottage or ward attendants see the resident as one of 30-90 individuals whose needs must be met. Perhaps in some instances parents appear to over-estimate the importance of their child's appearance because he, after all, is an extension of themselves and it hurts their pride to see him appear at less than his best. On the other hand, aides, because they have to deal always in terms of meeting mass needs rather than individual needs, may in some cases tend to become careless about helping the individual resident to appear at his or her best. The important factor here is that we place the emphasis where it belongs: on the resident himself rather than on the pride of the parents or the problems of the aide. When the resident's welfare becomes the focal point of the problem, he will be helped to achieve the best personal appearance possible for his own sake and not necessarily just to please the vanity of his parents or to flatter the ego of his attendant or aide, as the case may be.

#### Difficulties and Problems

According to information obtained from the questionnaires, the four most difficult problems relative to clothing institutionalized retardates were: difficulty of securing well-fitting clothing and shoes for the physically handicapped; destruction of clothing by tearing; inadequate clothing budgets and inadequate and poorly planned storage facilities in warehouses as well as in cottages and wards. Laundry problems, obtaining attractive, serviceable clothes and lack of adequately trained clothing personnel were further problems frequently mentioned.

The alleviation of the first problem will no doubt lie in further research within the clothing industry itself. Some research is already going on in this field and it is anticipated that when the need is made evident to the clothing manufacturers, further efforts will be made to fulfill the need.

Two publications which may be of some help to institutional personnel who have some responsibility in the field of clothing are:

"Self-Help Clothing for Handicapped Children"  
Publication Section  
National Society for Crippled Children and Adults  
2023 West Ogden Ave., Chicago 12, Illinois

**(50¢ per copy)**

"Clothes for the Physically Handicapped Homemaker"  
Address: Miss Clarice Scott, Institute of Home Economics  
U.S. Department of Agriculture Washington 25, D.C.

While a final solution to the first problem may of necessity lie outside the institution itself, it is quite evident that the problem of destructiveness of clothing is one which will have to be solved right at the source of trouble — with the residents themselves. Although no question appeared in the questionnaire related to a solution for destructive behavior, the attention of the Committee was directed to several institutions which are making an effort to arrive at some solution to this difficult problem. These institutions are experimenting with providing the overly-aggressive or hostile resident with a more constructive outlet for his energy. The description of one such program follows;

"Working with a group of older severely retarded men and women who had come to a standstill in their development, who exhibited highly aggressive, hostile feelings, and a marked inability to understand, Monson devised therapy gauged to meet their needs. The people involved perpetually ripped one another's clothing as well as mattresses and furniture materials. (Hair mattresses are used at Monson. They are continually being made over so that fresh mattresses will be in use. After sterilization, the mattress hair is left in matted piles and ordinarily sifted mechanically.) For this project the unsifted piles were gathered in a building separate from these people's residence areas. At nine in the morning they came as a group to the new location and under close supervision began their Mattress Hair Pulling Project. As a result of this rechanneling of dynamic energy, they uniformly learned to sit quietly, to identify with the task at hand, to follow directions, and they, of necessity, became better socialized. A good many worked out of the hair pulling into simple sewing, but in every case, their



level of hostility and withdrawal was dramatically reduced. Sleep was improved, personality positively developed, and eating habits reconditioned. " <sup>1</sup>

This example demonstrates clearly that in this institution the resident human worth is of real significance. From this instance, and from several others to which we could point, one may draw the conclusion that much of the destructiveness of clothing may very well be dramatically reduced and in many cases even eliminated if more ingenuous means were created for the outlet of hostilities.

Perhaps, too, there needs to be some research into the problem of "why" the hostilities develop which bring about these destructive tendencies. How many normal persons could stand the monotony of sitting day after day with no effort at stimulus in any form without degenerating to the stage of destructiveness exhibited by many institutionalized retardates? One may well conclude from the evidence presented that many of these unfortunate individuals are literally forced into a pattern of destructive action because of their daily environmental circumstances: too little space, too few attendants, little or no stimulation, and all too often, no one to care very much that this is the case. It would appear, also, that an increased effort to make the institutionalized retardate's clothing his own would result in less destruction. One is not nearly so likely to destroy that which he considers his very own, an extension of himself, as he is that which belongs to everybody and which has no particular significance to him as an individual. More adequate storage space on the wards, with increased emphasis on training attendants to realize the value of making a retardate's clothing his own, would also help in a large measure to solve the problem of destructiveness.

While visiting private residential centers and some State institutions for the retarded, staff and study Committee members have noted the practice of providing closet and drawer space for each resident. This has encouraged residents to care for their own clothing, with few problems of destruction, excessive laundering, etc.

The problems of inadequate clothing budgets, inadequate laundry equipment and lack of clothing specialists all stem from the basic problem faced by institutional administrators everywhere — insufficient funds. And this

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1. "Programming for the Severely Retarded." On Your MARC, Massachusetts Association for Retarded Children, Auburndale: January, 1961.

problem will not be satisfactorily resolved until this country's collective legislators have determined the answer to the philosophic question of whether institutions for the retarded exist to serve the welfare of the resident or whether the resident exists to serve the institution and all for which it stands. When this issue is faced squarely and answered honestly, it will point in the direction of finding solutions to many of the current problems that plague institutional administrators at every level.

### The Role of Clothing in the Lives of Institutionalized Retardates

The question, "Do you feel that clothing plays an important role in the training of residents?" was answered 100% in the affirmative. Information secured from the questionnaires presented conclusive evidence that institutional administrators and personnel believe wholeheartedly in the philosophy that attractive, colorful, well-fitted clothing plays an important role in the lives of their residents. From what one observes in the vast majority of institutions for the retarded, however, theory and practice seem to be at odds with each other. This may be due to the fact that the policy of the administrators may be countermanded by ward personnel. We must recognize, however, that the ward personnel may be forced to an attitude of "what's the difference ? " because of an inadequate supply of clothing for the residents (due to a limited budget), and also because of the difficulty of keeping clothing separated and in good order for wearing, due to inadequate and poorly planned storage space. It was indicated repeatedly in the questionnaires that an opportunity for the personal choice and care of their own clothing would:

- give residents a sense of individuality, pride of ownership, etc.
- serve to raise their self-esteem, making them more amenable to treatment.
- tend to make them happier people, thereby creating less discipline problems.

Unfortunately, the stern reality of budgeting prevented a vast majority of these same administrators from putting into practice a philosophy to which they wholeheartedly subscribed.

The dramatic result of an increased emphasis on the grooming habits of a group of severely retarded young adults was recently demonstrated at

an Occupation Day Training Center in New York City. The following excerpts from an article describing the program at the Center illustrate the change that can take place when these persons are looked upon as individuals who merit every opportunity for becoming more acceptable human beings:

"Before being admitted, the trainees at the Center were dependent on others for the most essential daily living activities such as travel, grooming and housekeeping... Their IQs average 40 and below. . . Once it (the center) was drab with dirty walls and floors, and an ill-kept, outmoded kitchen. It had an air of decay characteristic of a building after a long period of disuse. The Occupation Day Training Center is now a bright, cheerful place with freshly varnished floors and immaculate work, dining, and kitchen areas. Grooming tables have been built to teach young men to shave, and young women to apply makeup and fix their hair becomingly... Trainees were often dressed inappropriately for their age. Retardates close to thirty years old were dressed like young teenagers. Their inappropriate dress and poor grooming attracted public attention. Community reaction was unfavorable and even the professional staff was uncomfortable when appearing in public with some of the trainees. Following discussions with parents, grooming lessons and regular fashion shows, dramatic improvement was effected. Most trainees at the Center are now indistinguishable from their normal neighbors. They are able, inconspicuously, to avail themselves of community resources. Many eat in public restaurants, participate in social and athletic neighborhood activities, enjoy entertainment and travel independently to and from the Center." <sup>2</sup>

### The Role of the Clothing Specialist

Because of the magnitude of the clothing problem and because of its evident impact on the welfare of the individual residents, it becomes apparent that every residential center for the mentally retarded should have one or more (dependent upon its size) persons whose sole responsibility would lie in the

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2. The Education of the "Non-Educable". Occupation Day Center, New York City Chapter, Association for the Help of Retarded Children. New York: 1962.

area of clothing. Such person or persons should have had formal training in the study of textiles, clothing design, laundering problems and processes, and the psychological implications of clothing to residents, employees and parents. Duties of such a clothing specialist might very well include the following responsibilities:

Purchase of all clothing to be used at the institutions. Such purchases should be made with the total welfare of the individual residents as the primary consideration. The purchasing power of such agents should be protected by law so that in no case could political pressure be brought to bear by any individual or group of individuals in order to realize a profit for the party or parties interested.

Organization of central source of supply in order to make the most effective and practical use of the available space. Also, to give direct supervision to ward personnel in the organization or reorganization of ward clothing supplies in order to achieve the maximum use from the space allotted to clothing storage on the wards.

Serving as a liaison person between laundry and ward personnel in order to facilitate the flow of clothing from ward to laundry and back to ward. (A large number of questionnaires indicated difficulty in this area. One individual with the authority to check on all matters pertaining to laundry movement, with the authority to give directions or to hear grievances, would no doubt help to eliminate much of the friction which appears to exist in this particular area of institutional service.)

Serving as a supervisor of all clothing repair.

Designing and redesigning of special clothing to be used with the physically handicapped. This would require imagination, a sense of ingenuity and time for experimentation. Some information is now available concerning the designing of clothing for the physically handicapped and this knowledge could and should be utilized by clothing specialists in residential centers for the retarded, (Note references on page 50 under "Major Difficulties and Problems in Clothing Residents".)

Coordination with parents on clothing needs of the child.

The need for a trained person to supervise and coordinate the clothing program is evidenced by the following direct quote from one institutional administrator. It was typical of many similar statements:

"Providing and maintaining institutional clothing is one of the most time consuming, vexing problems faced. Parents seem to be particularly concerned with the way the program is handled. Maintaining a balanced inventory of needed items is difficult; coordination between laundry and ward personnel is a wide-spread problem. "

#### IV. CONCLUDING REMARKS

A study of the data relating to the Clothing survey led to these conclusions:

Even though the vast majority of administrators subscribe to the philosophy that sufficient attractive and appropriate clothing is of real importance to the welfare of their individual residents, they are hampered in carrying out this philosophy because of:

- inadequate clothing budgets (Median: \$28.73 annually) .
- inadequate storage facilities in warehouses and on cottage wards.
- difficulty of securing well-fitted clothing for physically handicapped.
- clothing purchases (in the majority of cases) made by individuals who have had little or no training or study in the area of clothing as well as little or no knowledge regarding the basic needs of the retarded.
- destruction of clothing by residents,
- inadequate laundry service coupled with poor coordination between laundry and ward personnel.

Many of the questionnaires contained suggestions and ideas for the alleviation of some of the problems and these were presented in some detail in the proceeding paragraphs in the DISCUSSION, In the final analysis, however, it is the belief of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN that these and many other problems relating to institutional management will not be finally resolved until those persons in positions of responsibility come to grips with this philosophic question: does the institution exist to serve the resident or does the resident exist to serve the institution and all for which it stands ? When this issue is faced squarely and answered honestly it will point in the direction of finding answers to many of the problems that plague institutional administrators at every level.

## V. RECOMMENDATIONS

1. Every residential center for the retarded should have a clothing specialist. (Duties broadly outlined under CONCLUDING REMARKS.)
2. Adequate clothing budgets should be provided.
3. Parents should be encouraged to furnish clothing for the residents when at all possible.
4. Present stores (operated in most cases by volunteers) should be expanded to include new clothing as well as the good used clothing now carried. This would encourage residents to make their own choice of clothing, either at the institutional clothing store, or under the supervision of their families in regular commercial channels.
5. Ample closet and drawer space should be provided for each resident of appropriate age and developmental level to encourage residents to care for their own clothing.
6. Close attention should be given to the proper fit of shoes; orthopedic shoes should be provided when indicated.
7. Special attention should be given to providing an adequate laundry service.
8. A positive program of activities should be initiated for all residents in order to relieve the boredom which often results in destruction of clothing by tearing, stuffing down the commodes, etc.

## VI. REFERENCES

1. "Programming for the Severely Retarded." On Your MARC. Massachusetts Association for Retarded Children, Auburndale: January, 1961.
2. The Education of the "Non-Educable". Occupation Day Center, New York City Chapter, Association for the Help of Retarded Children. New York: 1962.



A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED IN  
THE UNITED STATES

By  
THE NARC COMMITTEE ON RESIDENTIAL CARE

PART V. EDUCATION

## I. PHILOSOPHY AND ORGANIZATION OF EDUCATIONAL PROGRAMS

### IN STATE INSTITUTIONS

In this era of widespread provision of public school day classes for the mentally retarded, the terms "residential facility" and "school program" have, unfortunately, become almost antithetical. To the layman and, in some instances, to the professional as well, the term "residential facility" conjures up the picture of the "institution"; that is, a facility designed to provide custodial care for persons too severely afflicted to function at home or in the community without continuing supervision. In this picture of the "institution", formal educational programs involving curricula, teachers, teaching devices, and students play little or no role.

That such an erroneous conception of the history of educational provisions for the mentally retarded can persist is due only in part to the psychological tendency to believe what exists has always existed. The prevalence of this conception concerning the changing role of the residential facility must also be attributed to the subtle manifestation of derogatory attitudes which serve to omit or distort information or provide the basis for apathy. The current concern for the improvement of residential facilities and the report of which this paper is a part are indications that prejudice and misconception regarding mental retardation is diminishing and that a new appraisal of the role of the residential facility is in order.

To obtain a current description of educational programs in State institutions for the mentally retarded, one-hundred eleven State supported institutions in forty-eight States were queried regarding their educational practices. So that some indication of trends might be observed, this description has been compared with the results of previous studies.

From a comparison of the description, trends and the National Association for Retarded Children's policies on education, recommendations have been developed which are designed to help insure adequate educational opportunities for the retarded children in residence within our State institutions.

Contrary to the popular misconception referred to above, residential facilities for the mentally retarded have had a profound and lasting impact upon educational programs for all of the retarded. The earliest State-supported endeavors regarding the mentally retarded In the United States took the form development of residential facilities for the retarded. These residential

facilities were, contrary to popular belief, educational institutions. The very names of these early "institutions" reveal their educational purpose, design and intent. Thus, in 1848 the State of Massachusetts established an "experimental school for the teaching of idiots" (The Walter E. Fernald State School); in 1854 in New York, the Syracuse State School was erected; in 1852 a private school for the feebleminded was established in Pennsylvania. The historical evidence is clear that the earliest provisions for the mentally retarded involved State support of educational facilities. As Davies notes: <sup>1</sup>

"All these early schools for the feebleminded were organized in the hope of largely overcoming, if not entirely curing, idiocy by the application of the physiological method..."

Expanding population combined with the failure of the physiological technique of education resulted in a gradual shift in the orientation of the residential facility from that of an educational nature to that of a custodial nature. Educational programs begun with such high hopes gradually yielded to hopelessness and despair. Furthermore, to some extent the breakdown of the educational program in residential facilities stemmed from problems inherent in the very nature of these facilities. Constructed generally far from centers of population, the ensuing isolation served to keep the service performed by these residential facilities out of the awareness of the general population. Such isolation had a profound impact upon financial appropriations and upon the ability of these residential schools to attract dynamic, well qualified teaching staff. Inasmuch as these residential schools are often administered by some agency other than the State Department of Education, standards regarding employment of teachers, development of curriculum, and teaching methodology suffered from lack of stimulation, lack of financial support, and lack of professional guidance.

Further evidence of the important role which the residential facility has played in the development of educational programs for the mentally retarded in the United States is to be found in examination of the activities of the institutions in reference to the training of teachers of the mentally retarded. Frequently overlooked by professional educators and lay persons alike, is a recognition of the fact that from the turn of the century on into the '20's, the residential facility was the major training ground for prospect-

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1. Davies, Stanley P. Social Control of the Mentally Deficient. Thomas Crowell Co., New York: 1928, p. 39.

ive teachers of the mentally retarded. It was to the residential school that such persons turned for summer course offerings, workshops, seminars dealing with curriculum and educational methods for the mentally retarded. The advent of State certification requirements and course offerings in State teachers colleges did not take place until the late '20's and early '30's.

### Current Trends in Philosophy of Education in Institutions

Evidence of a trend in the direction of revitalization of the educational functions of the State residential facilities for the mentally retarded is provided in the results of a number of surveys. In 1952 a survey undertaken by White <sup>2</sup> polled 145 experts for their opinions concerning the role of the educational and training programs for institutions. Respondents to the questionnaire generally agreed that:

"It is the primary function of the institution to develop each child to his fullest capacity to lead as socially useful, emotionally mature and personally satisfying a life as he is able. If the individual's level of ability is such that it is practical and possible that with training he may return to the society as a contributing member, the school's program should be geared to that end for the individual. If it is clearly impossible for an individual to live outside a sheltered environment such as an institution provides, then it is the duty of the school to provide that individual with an education and training program that will enable him to live as rich, personally satisfying and useful a life as he is capable of living within the sheltered environment. "

In 1950 Turner, <sup>3</sup> Director of Training in Mansfield State Training School, took the position that the function of a department of education in a State institution is "to provide fundamental education for every child in the institution according to his needs . . . the school department is the heart of the institution." Turner further stated that "it is possible for this department to determine policies and establish procedures to provide fundamental education for all children in the institutional community."

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2. White, Wesley. The Development of the Education and Training Program of the Southbury Training School. Unpublished doctoral dissertation, Teachers College, Columbia University: 1952, p. 30.

3. Turner, Eloise. "The Function of the School Department in an Institution for the Mentally Retarded," American Journal of Mental Deficiency, Jan. 1950, p. 311.

In summarizing the activities of the National Association for Retarded Children during the decade 1950-1960, Dr. Elizabeth Boggs, former president of the National Association for Retarded Children, noted that:<sup>4</sup>

"NARC's program of service to the retarded has changed shape somewhat in the decade; it started out as comprehensive but somewhat elliptical polarized around the two foci of needed day schooling and equally needed residential care facilities."

As one of the main focal points of functioning of the NARC, educational programs in residential facilities felt the impact of the parents movement in the direction of altering the condition of stagnation which characterized the educational programs of many of these facilities. In summarizing the events of the previous decade, Boggs noted that:

"Programming has undoubtedly improved in a majority of institutions although not spectacularly during the decade. Of approximately 27,000 educable and trainable children of school age in residential institutions in the early part of the decade, only about 22% were enrolled in educational programs, notwithstanding the fact that the opportunities for education are often held out as a principle argument for removing such children from their homes. For comparative figures we must await the 1960 national census, but one can infer from such indirect information as the increase in the number of teachers employed by institutions, that educational programs therein are being expanded. Recreational activities are also improving, as have medical and psychiatric care and social service."

In summary, a review of the literature indicates a reawakening of awareness of the vital role which the education department can play in reference to the total functioning of the residential facility. Of fifty-two institutions responding to a questionnaire by Goldberg in 1957, forty-three retained in their names the word "school".<sup>5</sup> Levine, in

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4. Boggs, Elizabeth. Decade of Decision. National Association for Retarded Children, New York: 1957, pp. 7, 17.

5. Goldberg, I. Ignacy. "A Survey of the Present Status of Vocational Rehabilitation of the Mentally Retarded in State-Supported Institutions, American Journal of Mental Deficiency, April 1957, p. 698.

summarizing his 1954 survey of institutional programs, called for a philosophical orientation of these programs in the direction of consideration of the mentally retarded in institutions "as pupils instead of patients."

## II. CURRENT TRENDS IN STRUCTURE OF EDUCATIONAL PROGRAMS IN INSTITUTIONS

### Number of Programs

Evidence that changes in philosophy noted above are being translated into activity leading to the expansion and improvement of educational programs within institutions are to be found in the results of a number of surveys.

Levine, School Principal, Sonoma State Home, Sonoma, California, writing in January 1954 after noting the criticism leveled at State schools for not fulfilling the educational needs of their patients, pointed out that as of that writing there had been no detailed study of educational programs in institutions throughout the United States. His survey of the educational programs of ninety-two State supported schools and institutions for the mentally retarded in the United States reported the results of a questionnaire returned by fifty-one schools. Of the fifty-one schools completing the questionnaire, forty-five indicated that formal educational programs were offered to their patients. The survey indicated that a major difficulty confronting these institutions was inadequate appropriations for educational needs. As Levine stated:<sup>6</sup>

"The lack in this area has been responsible for curtailing programs in terms of construction, curriculum, number of patients enrolled, and teachers' salaries."

Many of these institutions reported great hardships as "result of inadequate space and facilities", "classes in some institutions are being held in garages, clothing closets, dining rooms, therapeutic bathrooms, employees' bedrooms, etc."

In 1956, Cassell,<sup>7</sup> Director of Training at Mansfield Training School, Connecticut, undertook a nationwide sampling of problems affecting the education of the mentally retarded in residential schools and in public day schools. Of the thirty-eight State schools responding, the five most serious problems as reported by these institutions were in rank order:

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6. Levine, Samuel. "Educational Problems in State Institutions for the Mentally Retarded, " American Journal of Mental Deficiency, Jan. 1954, p.403,
  7. Cassel, John. "A Survey of the Major Problems Affecting the Education of the Mentally Retarded in Residential Schools, " American Journal of Mental Deficiency, Jan. 1956, p. 470.

1. Shortage of trained personnel
2. Lack of teacher training facilities
3. Shortage of suitable teaching materials and equipment
4. Inadequate classroom space and facilities
5. Unattractive pay differential for special class teachers

In 1961 the National Association for Retarded Children surveyed one-hundred eleven State institutions. Responses on educational programs were received from ninety-three. Four of these responded that they were hospitals for severely retarded and therefore had no educational program, leaving data on eighty-nine institutions. Thus, the NARC survey revealed educational programs in eighty-nine institutions compared to forty-five in the Levine survey. While the two surveys were not definitive, the results do indicate an increase in the number of institutions offering formal educational programs.

In 1954, Levine reported that;

"Nearly 50% of the institutional teachers have had four years or less experience with this group; 17% of these are in their first year of teaching."

He noted:

"Another facet of the personnel problem is the shortage of suitably trained teachers to work in institutions for the mentally retarded. Less than 50% of the teachers in State institutions for the mentally retarded have general teaching certificates, with only 40% of the entire group having college degrees. The picture was even more dismal in terms of credentials for teaching the mentally retarded, with only 10% having these credentials. This is due to the fact that few States require such credentials, and few educational institutions (colleges and universities) provide such training programs. "

The responses to our survey revealed that the education program is supervised by the State Department of Education in fourteen institutions. One did not answer this question. The fourteen institutions where the State Department of Education supervision is provided are:



Mansfield State Training School	Connecticut
Walter E. Fernald State School	Massachusetts
Caro State Hospital for Epileptics	Michigan
Brainerd State School and Hospital	Minnesota
Montana State School and Hospital	Montana
Laconia State School	New Hampshire
Woodbine State School	New Jersey
Apple Creek State Hospital	Ohio
Gallipolis State School	Ohio
Ladd School	Rhode Island
Abilene State School	Texas
Travis State School	Texas
Rainier School	Washington
Lakeland Village	Washington

In reference to teacher certification, whereas Levine noted only 10% of teachers certified, the present survey revealed fifty-nine institutions requiring State certification to teach children at the educable *level* and forty-three institutions requiring certification to teach children at the trainable level. Fifty institutions reported requiring a college degree to teach educable children and thirty-six reported requiring such a degree to teach children at the trainable level. Thus, from 1954 to 1962, gains are noted in the degree to which supervision of education programs in institutions is the responsibility of the State Departments of Education.

Further gains are noted in the number of institutions requiring certification and bachelor's degrees for teachers of institutionalized retarded children.! Responses to the present study indicated that low salary is the major deterrent to hiring and keeping adequately trained teachers.

#### Number of Children Enrolled

In 1954 Levine noted:

"The forty-five schools and institutions that supplied data, indicated that school programs are provided for from 3.2 to 100% of the total patient population. "

Of nearly 75,000 residents in these institutions the total pupil enrollment was 10,207. The school enrollment for all institutions averaged 13.7% of the institution population. A "pronounced lack of educational

opportunities for the pre-school and adult retarded groups" was noted by Levine. "The largest percentage of pupil enrollment was in the fifty to sixty-nine I.Q. range, being slightly over 56%."

As noted earlier, Boggs in 1960 reported:

"Of approximately 27,000 educable and trainable children of school age in residential institutions in the early part of the decade, only about 22% were enrolled in educational programs..."

The present survey indicates that 25% of the mildly and moderately retarded residents in the eighty-nine institutions surveyed are enrolled in formalized education programs. Since this figure represents the percentage of the total populations, it indicates a substantial increase over the percentage reported by Boggs. Thirty-five percent of the mildly retarded were enrolled in formal education programs as compared with 19% of the moderately retarded. A breakdown of the number of residents enrolled in formal education programs in the eighty-nine institutions surveyed is presented below:

	<u>Number</u>	<u>Percent</u>
Mildly MR in 89 institutions	34,452	35%
Mildly MR in educable classes	11,972	
Moderately MR in 89 institutions	57,024	19%
Moderately MR in academic classes	11,010	
TOTAL mildly and moderately MR in 89 institutions	91,476	25%
TOTAL mildly and moderately MR in classes	22,982	

There were also indications of increased enrollments in activities of in educational nature. The breakdown of the mildly retarded and moderately retarded in pre-school, school-age and adult programs is reported below:

Pre-school mildly MR in programs	1,021
7-20 years mildly MR in programs	8,570
<u>20 plus</u> years mildly MR in programs	<u>6,392</u>
TOTAL	15,974

Pre-school moderately MR in programs	1,492
7-20 years moderately MR in programs	10,025
<u>20 plus</u> moderately MR in programs	<u>11,132</u>
TOTAL	22,649

Of the total of 91,476 mildly and moderately retarded individuals of all ages in the 89 institutions, 22,982 are reported to be "in classes". This figure, although it cannot be compared directly with the estimate by Boggs noted earlier due to the difference in the age criterion employed, does indicate a substantial increase.

There also appears to have been an increase in enrollment as compared to the Levine figure of 10,207. More detailed analysis must await further study using similar criteria.

Of note is the number of persons reported to be "in programs". These "programs" are considered to be of an educational nature although they may not necessarily involve utilization of a "classroom" or a qualified "teacher". The figures reported in this category indicate an increased awareness of the need for programs at the pre-school level and an increased awareness of the need for activity programs for those beyond the school age,

### III. SUMMARY

A review of the literature reveals mounting awareness of the educational function to be performed by residential schools. This awareness is reflected in increased State Education Department supervision of such programs, increasing number of facilities requiring State certification for teachers and the increasing number of facilities requiring a college degree for such teachers. In addition, this awareness is reflected in the fact that the eighty-nine institutions surveyed by the NARC Committee on Residential Care showed awareness of the need for pre-school and activity programs. Definitive information revealing the percentage of children of school age served by the residential facilities awaits current census figures. However, there does appear to have been an increase in the total number of residents involved in some form of "educational program".

#### IV.

##### RECOMMENDATIONS

Although the findings indicate an increase in number and quality of educational programs, there still appears to be a need for:

1. State Education Departments to assume more responsibility for the educational programs in institutions.
2. More attention to be given to formalized educational programs of both educable and trainable levels.
3. Improved requirements for teachers in institutions to coincide with requirements in community classes, particularly with the trainable.
4. Increased appropriations to institutions in the form of funds designated for school building, equipment, and supplies.
5. Placement of salaries of teachers in residential facilities on a scale similar to that of teachers in the public schools of the State.
6. Establishment of scholarship funds to enable teachers in residential facilities to enroll in post-graduate training programs.

REFERENCES

1. Davies, Stanley P. Social Control of the Mentally Deficient. New York; Thomas Crowell Company, 1928.
2. White, Wesley D. The Development of the Education and Training Program of the Southbury Training School, Southbury, Connecticut. Unpublished doctoral dissertation, Teachers College, Columbia University, 1952.
3. Turner, Eloise. "The Function of the School Department in an Institution for Mentally Retarded." American Journal of Mental Deficiency, Jan.1950, p.311.
4. Boggs, Elizabeth. Decade of Decision. New York: National Association for Retarded Children, 1957.
5. Goldberg, I. Ignacy. "A Survey of the Present Status of Vocational Rehabilitation of the Mentally Retarded Residents in State-Supported Institutions," American Journal of Mental Deficiency, April 1957, p. 698.
6. Levine, Samuel. "Educational Problems in State Institutions for the Mentally Retarded." American Journal of Mental Deficiency, Jan.1954, p. 403.
7. Cassel, John. "A Survey of the Major Problems Affecting the Education of the Mentally Retarded in Residential Schools (Public and Private) and in Public Day Schools." American Journal of Mental Deficiency, Jan. 1956, p. 470.

A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED  
IN THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

PART VI. RECREATION

## I. INTRODUCTION

Although recreation is a basic human need, recognition of it as it applies to the retarded often has been overlooked.

Yet recreation is considered one of the essential elements in the institution's commitment to help the mentally retarded attain their fullest self-realization<sup>1</sup>.

The National Recreation Association concludes from a study of Organized Recreation Programs in 3000 Hospitals and Institutions in the U.S. that recreation plays an important role in the total care of the patients and residents. The study also revealed that recreation programs in hospitals and institutions varied widely throughout the United States.<sup>2</sup>

The Residential Committee of the National Association for Retarded Children, realizing the importance of recreation in a total institution program, decided to identify the current recreational practices in these institutions.

To accomplish this dual purpose a section of the questionnaire distributed to the 111 institutions was devoted to recreation. This section contained 14 questions dealing with the following areas: programs, personnel training and volunteers, facilities and community resources.

The questionnaire was returned by 101 institutions located in 48 states. However, 3 of these institutions who returned the questionnaire did not respond to the questions contained therein.

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1. Report of the Task Force on Prevention, Clinical Services and Residential Care, The President's Panel on Mental Retardation, U.S. Dept. of Health, Education and Welfare, Washington, D.C., 1962, p.,54.
  2. Silson, John E., Cohen, Elliot M., Hill, Beatrice, Recreation in Hospitals, National Recreation Association, New York: 1959.



## II. DATA RECEIVED FROM QUESTIONNAIRE ON RECREATION

Presented in this section are questions contained in the recreation questionnaire plus a tabulation of the institutions' responses. . For facility of reading and orderliness, the questions have been placed under categories:

### Programs

1. a.	QUESTION	NO. INSTITUTIONS			
	Does a recreation program now exist in your institution ?	Yes	97		
		No	1		
b.	The recreation program serves the following classification of residents:				
	CLASSIFICATION TO DEGREE OF MR	NO. INSTITUTIONS			
	Mildly retarded	Yes	<u>93</u>	No	<u>4</u>
	Moderately retarded	Yes	<u>93</u>	No	<u>4</u>
	Severely and profoundly retarded	Yes	<u>91</u>	No	<u>6</u>

At the time of this survey one institution who responded no to the question dealing with mildly and moderately retarded had no residents in this classification. Another institution answered no to recreation program for severely and profoundly retarded since it did not have any residents in this category at the time of the survey.

2.	QUESTION	NO. INSTITUTIONS			
	Number of Institutions	Yes	<u>89</u>		
		No	<u>4</u>		
		No ans	<u>4</u>		

The four institutions reporting no did not have any physically retarded handicapped residents.

### Program Activities

3. What activities are included in your program?

92	of the institutions reported the use of Entertainment						
91	"	"	"	"	"	"	Bus Rides
90	"	"	"	"	"	"	Simple Games
88	"	"	"	"	"	"	Quiet Games
86	"	"	"	"	"	"	Movies
85	"	"	"	"	"	"	Soft Ball
83	"	"	"	"	"	"	Dances
83	"	"	"	"	"	"	Basketball
81	"	"	"	"	"	"	Arts & Crafts
81	"	"	"	"	"	"	Bowling
80	"	"	"	"	"	"	Volleyball
76	"	"	"	"	"	"	Swimming
76	"	"	"	"	"	"	Baseball
70	"	"	"	"	"	"	Square Dances
66	"	"	"	"	"	"	Boy Scouts
57	"	"	"	"	"	"	Camping
49	"	"	"	"	"	"	Girl Scouts
40	"	"	"	"	"	"	Hobby Clubs
32	"	"	"	"	"	"	Model Airplanes
30	"	"	"	"	"	"	Band
20	"	"	"	"	"	"	Cheerleading
24	"	"	"	"	"	"	Cub Scouts
24	"	"	"	"	"	"	Brownies
14	"	"	"	"	"	"	Soccer
9	"	"	"	"	"	"	Stamp Collecting

The above activities were checked as being included in the institutional recreation program.

### Camping

4.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Does your institution have its own camping program?	Yes	<u>44</u>
	No	<u>44</u>
	No ans.	<u>9</u>

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Their camping program was listed as follows:

- 20 of the institutions had Day Camps
- 17 of the institutions had Residential Camps
- 17 of the institutions had both

Scouting

5.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Do you have a scout program?	Yes	<u>71</u>
	No	<u>22</u>

The breakdown of the scout program was listed as follows:

66 of the institutions had Boy Scout programs that accommodated 1493 boys  
49 of the institutions had Girl Scout programs that accommodated 1013 girls  
24 of the institutions had Cub Scout programs that accommodated 337 boys  
24 of the institutions had Brownie Troops that accommodated 196 girls

Activities for Severely Retarded

6.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Do you have recreation programs for the severely retarded ?	Yes	<u>91</u>
	No	<u>6</u>

The following activities were described as being used for the severely retarded :

87 of the institutions used Simple game activities  
62 of the institutions used Unorganized playground activities  
67 of the institutions used Singing  
64 of the institutions used Hiking  
67 of the institutions used Organized playground activities  
56 of the institutions used Rhythm  
53 of the institutions used Musical games  
55 of the institutions used Finger painting  
55 of the institutions used Arts and Crafts

Personnel Training

7.a.

QUESTION	NO. INSTITUTIONS	b. QUESTION	NO. INSTITUTIONS
Do you have a person in charge of your recreation program?	Yes <u>90</u> No <u>0</u> No ans. <u>7</u>	Do you have a person assigned to full-time re-recreational duties ?	Yes <u>93</u> No <u>5</u>

8.

<u>QUESTION</u>	<u>NO. INSTITUTIONS</u>
Do you offer in-service training to recreation personnel?	Yes <u>69</u> No <u>24</u>

Salaries

9.a.

<u>MINIMUM SALARY</u>	<u>NO. INSTITUTIONS</u>
\$2,000-\$3,000	<u>13</u>
\$3,000-\$4,000	<u>29</u>
\$4,000-\$5,000	<u>21</u>
\$5,000-\$6,000	<u>11</u>

<u>MAXIMUM SALARY</u>	<u>NO. INSTITUTIONS</u>
up to \$2,580	<u>2</u>
up to \$3,900	<u>6</u>
up to \$4,980	<u>19</u>
up to \$5,845	<u>17</u>
up to \$6,840	<u>11</u>
up to \$7,872	<u>12</u>
up to \$8,940	<u>6</u>
up to \$9,454	<u>1</u>

Volunteers

10.a.	<u>QUESTION</u> <u>NO. INSTITUTIONS</u>			b.	<u>QUESTION</u> <u>NO. INSTITUTIONS</u>		
	Do you use	Yes	<u>74</u>		Do you use	Yes	<u>58</u>
	volunteers in				college and		
	your recreation	No	<u>24</u>		high school	No	<u>22</u>
	duties?	No ans.	<u>2</u>		students as		
					volunteers ?	No ans.	<u>13</u>

Facilities

11. Please check those recreational facilities available to you either on a full-time or part-time basis.

<u>FULL-TIME FACILITIES AVAILABLE ON THE INSTITUTIONAL GROUNDS</u>	<u>NUMBER OF INSTITUTIONS</u>
Playgrounds	93
Auditoriums	87
Athletic Fields	79
Canteens	75
Picnic Areas	69
Gymnasiums	67
All Purpose Courts	38
Swimming Pools	33
Tennis Courts	29
Day Camps	23
Resident Camps	9
Bowling Alleys	13

PART-TIME FACILITIES AVAILABLE IN  
THE COMMUNITY OR USED OCCASIONALLY

NO. OF INSTITUTIONS

Swimming Pools	29
Day Camps	28
Bowling Alleys	26
Resident Camps	15
Picnic Areas	12
Gymnasiums	5
Auditoriums	3
Canteens	4
Athletic Fields	2
Tennis Courts	2
All Purpose Courts	1

Community Resources and Facilities

12. <u>QUESTION</u>	<u>NO. INSTITUTIONS</u>	
Do you utilize community resources in your recreational program ?	Yes	<u>92</u>
	No	<u>1</u>

<u>TYPE OF COMMUNITY SERVICE</u>	<u>NUMBER OF INSTITUTIONS</u>
Circus	85
Sporting Events	80
Parades	79
State Parks	74
Swimming Pools	59
Zoo	51
Roller Skating Rinks	25
Beach Parties	21
Ice Capades	20
County or State Fairs	10
Big League Ball Games	10
Community Christmas Parties	10

13. Examples of Unique Recreation Activities in Residential Care Institutions

Alabama	- Street Dances, inter-ward parties, boys invite girls to their wards for parties and the girls in turn invite the boys, under supervision. Patient Committees from each ward plan.
Colorado	- Miniature train rides and burro rides, tap dancing, tumbling, Easter egg hunt.
Connecticut	- Six to eight football games with junior-high and senior-high school football teams. - Soapbox Derby, visit of "Santa Claus" in helicopter. - Amateur night, Kite Derby.
District of Columbia	- May Day Queen.
Delaware	- Calisthenics program with leader.
Iowa	- Athletics, banquet, trophy, dance, speeches by patients.

Indiana	Each cottage has a full-time recreation aide and a recreation room with activities 12:00 noon to 8:30 p.m. Tuesday-Saturday.
Illinois	Annual summer festival (2,000 patients) all classifications participate in dances, games, drills, band and drum corps. Maypole dances presented on campus under floodlights. "Chin up" club of all physically handicapped also annual stage production.
Kansas	Aggressive patients participate in any hitting, kicking or throwing activity.
Louisiana	Full and completely lighted amusement park including swimming pool.
Maryland	"Keeping dressed". Bus pulls up to cottage at unannounced time. All "dressed" may go — it works. Indoor swimming pool 75' x 25' open year 'round. Large asphalt area for year 'round use such as bike riding and skating.
Massachusetts	-Patient's Gift Fund of several thousand dollars which they use for trips and outings.  - Minstrel Show. (Gay Nineties, Barber Shoppers).  - Hay Rides.
Michigan	Annual formal dance with all the trimmings, 50-60 couples. Annual Parent's Day picnic. Employees sponsor "Pancake Supper" to provide Scouting equipment. Spring Review (minstrel-type activity). Photo-quiz contest. Photos are taken of various places on the grounds which are difficult to identify. These are mounted on a board, circulated to the buildings. Patients are encouraged to submit their lists 6t trying to identify them. Prizes are given to the most nearly correct answers. Gay 90's presented by "barber shoppers".
Minnesota	- All students have passes to city theatre and many attend approved movies at any time. We pay flat fee each month.

Montana	Wheel chairs can be attached to a merry-go-round and ferris wheel. Residents attend circus' and rodeo's as wheel chairs are sent on ahead. Swan-boat rides on a lagoon with replica of Ft. Apache at end. Throughout the ride, there are stuffed Indians peeking from the brush and also stuffed animals. The boat is propelled by a bicycle arrangement. All facilities are made to carry adults instead of being restricted to small children.
Nebraska	Wheel-chair parade for the handicapped. Snow-cone machine.
New Mexico -	Four formal evening dances with corsages and outside orchestras, Training school personnel and children are involved.
New York	Miniature bowling for the severely retarded. Bicycles and scooters, go carts, tractor trains. Drums and bugle corps participate in community activities.
North Carolina	-Train ride and cart pulled by a tractor which is made from equipment used to transport baggage at airports.
North Dakota -	- Folk-dancing for very small children.
Ohio	Cottage competitive play with prizes.
Oregon	Therapy-swimming for severely physically handicapped.
Rhode Island-	Big-Brother and Big-Sister Program. Golden Age Club. Kite Derby and Fourth of July Parade. "Sunshine Wagon" for physically handicapped. "Pee Wee" Basketball League and Clown Basketball Game.
Tennessee -	Residents eat with the staff for etiquette training. campers train, daily rides.
Texas	Track meet. Recorded music over speaker system.
Washington -	Thirty-five passenger pontoon boat with regular boat rides on lake. Merry-go-round. Fishing for spastics. Archery.



- W. Virginia - Handicraft. Competing with normal adults at State Fair-pupils placed 15-1sts and 16 "seconds" ribbons.
- Wisconsin - Children (under 30 IQ) help prepare floats and participate in parades.

### III. DISCUSSION

The goals of a recreation program for the mentally retarded do not differ greatly from the goals of a recreation program for children of average intelligence, social and physical development. These goals are:

1. To provide the retarded with fun, personal enjoyment and satisfaction.
2. To develop skills and abilities,
3. To develop desirable social relationships and to increase sociability.
4. To expand interests and experiences.
5. To develop physical health and abilities.
6. To relieve tensions arising from mental, emotional and physical stresses.
7. To provide opportunities to explore vocational and social pursuits.

When carefully planned and implemented, the recreation programs can be an important factor in helping the retarded and his family accept institutional living. Re-creation does help the retarded adjust socially and psychologically to the institution. [For the long term residents and, of course, the other residents, recreation helps to prevent further physical, social and mental deterioration. There is little doubt that anyone would question the value of recreation for the retarded, especially for those in institutions.]

#### Discussion of Data

##### Program

The survey revealed that all of the institutions which responded to the survey with the exception of one, do provide some form of a recreation program for the retarded. Although this in itself does not imply that the institutions are doing their best to fulfill their commitment to help the mentally retarded attain their fullest realization, it does show, however, that these institutions are making an attempt to meet their commitment, at least with recreation programs.

The survey further indicated that most institutions provide recreation for the various classifications (degrees) of retarded, 93 had programs for the mildly and moderately retarded, while 91 of the 98 had programs for the severely and profoundly retarded, (see figure 1b for further details). In addition to serving the various gradations of retarded, 89 of the institutions also provided recreation activities for the physically handicapped retarded. The four institutions who responded no to this question indicated they did not have any physically handicapped retarded residents. In addition, many of the institutions indicated that they involved the physically handicapped mentally retarded only as they were able to take part. The

activities for them ranged from grooming to bus rides and included such things as: simple games, rhythm bands, quiet games, arts and crafts, singing, hobbies, parties, movies and storytelling.

### Program Activities

The results reveal that group sports and group activities are featured in most institutions. Bus rides also appeared to be a part of most of the institutions' recreation programs. Social activity such as entertainment and dances are also included in most of the institutional programs. Individual sports and the more difficult hobbies are available in a smaller number of institutions. For example, only 7 institutions indicated that stamp collecting was an activity, and 21 that model airplanes was an activity. Those institutions with smaller resident ratio to staff were involved in these individual sports and hobbies in addition to other activities. This might mean that these more involved and complex activities require more individual attention than most institutional staffs are in a position to give. Consequently, the staffs may concentrate on mass group activities and games which provide recreation for large numbers of residents at one time.

### Camping

Of the 97 institutions that reported they had a recreation program, 48 stated that they have a camping with 44 of the institutions reporting that they have no camping program. 20 of the institutions said they had day camps, 17 residential camps, and 11 indicated they had camps, but no breakdown. 14 of the 48 institutions had both kinds of camps, residential and day, in their recreation program. The numbers of campers of those who responded range from a low of 15 to a high of 1500, with a total of 12,956 campers in the 48 institutions. Although we have no way of knowing, from this study, if camping for residents in institutions is on the increase, we do know that camping in the community for the mentally retarded has been on the increase. We also know that camping for the mentally retarded is very helpful for their overall development.

### Scouting

Of the 98 institutions reporting, 76 stated that they maintained a scout program, while 22 reported that they did not have a scout program.

The breakdown of the scout program listed 66 institutions had Boy Scout programs, that accommodated 1493 boys. 49 of the institutions had Girl Scout programs that accommodated 724 girls. 24 of the institutions had Cub Scout programs that accommodated 309 boys. 24 of the institutions had Brownie Troops which accommodated 153 girls.

Note that the numbers of institutions listed above are somewhat smaller than are shown in figure 5, because not all of the institutions reporting scouting programs answered the later questions on the number of participants in the troops or packs. The total number of participants, therefore, is actually higher than the 2650 shown.

### Severely Mentally Retarded

Activities for the severely mentally retarded were reported by 91 of the 97 institutions who reported they had recreation programs, 7 indicated they did not have recreation programs for the severely or profoundly mentally retarded. One of these 7 who responded 'no' did not have any severely or profoundly retarded residents.

Figure 6 shows the activities provided for the severely and profoundly retarded. As might be expected, simple and unorganized games (87 institutions) are the most numerous, while the more complicated games and hobbies are provided in fewer institutions (67 institutions). Some of the other activities reported and not reflected in Figure 6 included: dancing, marching, movies, bus and train rides, cottage music activity programs and wading pool activities.

### Personnel and Training

90 of the 97 institutions who had recreation programs responded that they had a person in charge of the recreation program- However, only 68 of these 90 had a full-time director or supervisor of recreation. The range of full-time employees was from 1 to 23. The mode was 2 employees in 19 institutions; 10 institutions had 1 full-time employee; 11 with 3; 9 with 4; 10 with 5; 7 with 5 and 6; and 6 with 8. 2 institutions had 5 employees with populations under 500 residents. 3 institutions had no employees in recreation for population of 500 - 1,000. One institution with a population under 500 had a single recreation employee. A very large institution with a population between 5,500 and 6,000 had only 7 full-time employees. Although not contained in this survey, this institution now has a population well over 6,000 with the same amount of employees.

One would question how so few employees can provide satisfactory recreational activities and skill training to such large populations.

Most of the institutions (69) offered in-service training to its recreation personnel.

In addition to the full time employees, 78 institutions reported that they employed part-time summer recreation staff. This number ranged from 1 to 22, with a mode of 10.

### Use of Volunteers

From the 93 institutions answering this question, 74 of the institutions stated that volunteers were used in their recreation programs, while 24 of the institutions stated that volunteers were not used. 58 of the 74 institutions indicated that they used high school and college students as volunteers and said they did not use students as volunteers.

The areas where volunteers were used in the recreation program included the following: parties, dances, off-ground activities, ward and rehabilitation areas, games, trips, picnics, camping and scouting, movies, letter writing, Christmas shopping, walks, spastic areas, swimming pools, playground, clubs, hobbies, arts and crafts, leisure time programs and physical education programs.

### Facilities

The number of institutions in which the various facilities are available on a full-time and part-time basis is shown in Figures 11a and 11b. These figures show that the major generally used recreational facilities are available at most institutions. Facilities for camping and sports such as tennis and bowling are available at only a small percentage of the institutions reporting.

Most institutions had playgrounds, auditoriums, athletic fields, canteens, picnic areas and gymnasiums available. All but one (92) of the institutions that responded indicated that they utilize community resources and facilities for their recreational programs, yet, only 28 utilized day camps, 29 swimming pools, 26 bowling alleys, in the community. A still smaller number (15) used resident camps and 12 utilized picnic grounds in the community.

Most of the institutions took advantage of special events in the community- 85 institutions sent residents to the circus, 80 to sporting events, 79 to parades, 59 to swimming in the community.

#### IV. CONCLUSIONS

1. Most institutions provide a recreation program for their mentally retarded residents. The programs generally include activities for residents in the four classifications or degrees of mental retardation: mild, moderate, severe and profound. However, the recreational activities for the severe and profound generally consist of simple and unorganized games.
2. Most institutions conduct group sports and group activities in their recreation programs. Fewer than half of the institutions engaged in individual sports and hobbies. There was greater use of individual sports and hobbies in institutions that had a smaller resident ratio to staff than in institutions with a larger ratio.
3. Although many of the institution recreation programs have a director of recreation, some of the programs are inadequately staffed with full-time personnel.
4. Most institutions have recreational facilities available within their institutional grounds. The majority of these institutions tend to use their institutional recreation facilities rather than take advantage of the available community recreation facilities.

## V. RECOMMENDATIONS

1. There is a need to explore and try other kinds of recreational activity for the severely and profoundly retarded.
2. There is a need for institutions to take a careful look at their recreational programs to determine if they are providing a well balanced recreation program with various recreational activities that meet psychological and social needs of the residents. At the same time these institutions should examine their resident staff ratio to ascertain if they have sufficient staff to achieve a balanced program.
3. There is a need for more full-time recreation personnel in institutions. Likewise, there is a need to reduce the resident-staff ratio.
4. Since the philosophy of institutions today is that the institution is an integral part of a community, it would be desirable for institutions to take full advantage of existing community resources.

VI. REFERENCES

1. Report of the Task Force on Prevention. Clinical Services and Residential Care. The President's Panel on Mental Retardation, U.S. Dept. of Health, Education and Welfare, Washington, D.C. 1962, p. 52.
2. Silson, John E., Cohen, Elliot M., Hill, Beatrice. Recreation in Hospitals. National Recreation Association, New York: 1959.



## II. DATA FROM QUESTIONNAIRE ON RELIGIOUS NURTURE

Questions concerning religious education for the retarded in residential centers were presented in three general categories: Programs, Facilities and Chaplaincy Service. Information received in answer to the specific questions is presented below with brief comments in some instances.

### Programs, Facilities and Chaplaincy Service

#### QUESTION NO. INSTITUTIONS

#### b. QUESTION NO. INSTITUTIONS

Does your institution have a religious character training program of any kind?	Yes	<u>88</u>	If answer is negative, do you anticipate the development of such a program in the future ?	Yes	<u>5</u>
	No	<u>6</u>		No	<u>1</u>
	No ans.	<u>0</u>		No ans.	<u>0</u>

Several reported no organized programs but listed religious activities. The fact exists that 88 out of 95 institutions reporting indicated some effort toward religious nurture.

#### QUESTION NO. INSTITUTIONS

#### b. QUESTION NO. INSTITUTIONS

If you have such a program do you have a full time spiritual advisor or a resident Chaplain?	Yes	<u>50</u>	Is the salary of your Chaplain paid by:	
	No	<u>27</u>	State	<u>79</u>
	No ans.	<u>27</u>	State or Local Council	
			Churches	<u>6</u>
			Other	
			No ans.	<u>1</u>

#### c. What is the annual salary of your Chaplain?

Based on 44 reports which listed salaries and using the median in the range indicated, these are the conclusions:

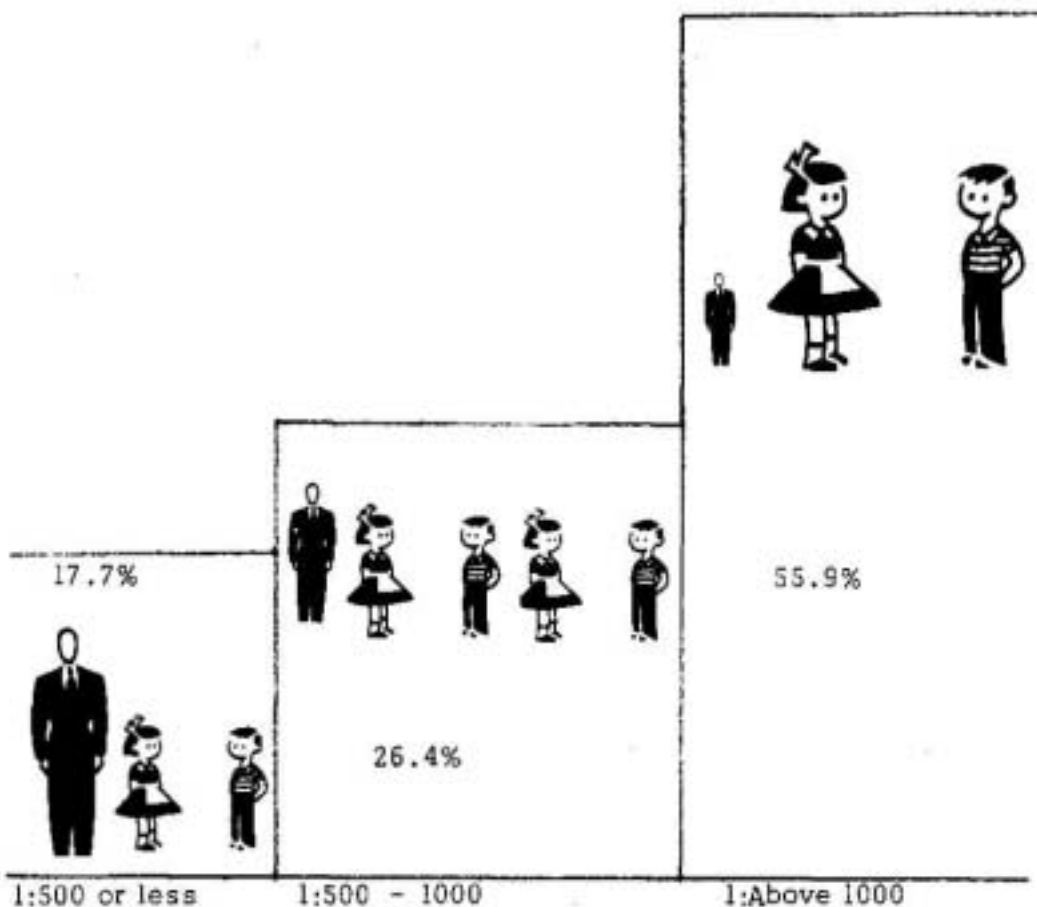
Lowest annual salary	\$ 600
Highest annual salary	\$9172
Range of median salaries	\$ 5266 - 6716

Part-time salaries were impossible to determine; one institution reported \$10.00 and another reported \$20.00 per visit to clergymen on call.

- d. What is the ratio of residents to the Chaplain(s) serving your institution?

This was difficult to determine accurately due to the fact that a number of institutions reported both part-time and full-time clergy service. In many instances the number was not clearly defined. From 38 reports which were quite accurate on this point, however, the following results were obtained:

CHAPLAIN - RESIDENT RATIO



Special Services for Catholic and Jewish Residents —

3. Assuming that the resident Chaplain plans and supervises the overall religious activities, what, if any, special plans or services are offered for the benefit of your Catholic and Jewish residents ?

Catholic

- |    |   |           |
|----|---|-----------|
| a. | Specifically stating that there is a weekly Mass, regular Confession and Holy Communion, First Communion, Confirmation and regular instruction: | <u>66</u> |
| b. | Reporting part-time priests with Masses scheduled less regularly or not at all and very little other activity:                                  | <u>22</u> |
| c. | Reporting no services:  | <u>3</u>  |
| d. | Reporting few Catholic with resultant limited programs, often with lay instructors and a priest available only on emergency basis.              | <u>5</u>  |
| e. | No answer   | <u>19</u> |

Two questionnaires specified mass Confirmations by the visiting Bishop; these services were held for the severely retarded confined to wards. 10 institutions indicated that residents were taken out to local churches for Mass; Easter and Christmas were mentioned in this regard.

Jewish

- |    |  |           |
|----|--|-----------|
| a. | Institutions having a Rabbi visiting regularly, weekly or biweekly, with special services on occasion:                                   | <u>31</u> |
| b. | Institutions reporting no regular services for Jewish residents because there are few or none: (Three have Rabbi come only when called.) | <u>51</u> |

Eight institutions reported that Jewish residents were taken out to local synagogues for festivals and Holy Days; one reported that Jewish residents go home for religious festivals and one also reported that Jewish residents attended Protestant services. Special observances of Bar-Mitzah and Confirmation were mentioned only a few times.

There was little indication that special food service was provided for either Catholic or Jewish residents; two institutions reported that dietary elements were considered for Jewish residents at holiday times. There was no direct question on this subject, however.

Answers to all parts of question 3 were somewhat sparse; it appears, however, that a substantial number of institutions are making some effort to meet the religious needs of their Catholic and Jewish residents.

Chapels

QUESTION NO. INSTITUTIONS

b. QUESTION NO. INSTITUTIONS

Do you have a chapel or other building designed for workshop and religious training programs?	Chapel	<u>17</u>	If you do not have a chapel at present	Yes	<u>41</u>
	Other	<u>60</u>	do future plans for the institution include one ?	No	<u>34</u>
	Facilities			No ans.	<u>9</u>
	No ans.	<u>17</u>			

It was interesting to note that one Association for Retarded Children had assumed responsibility for building a chapel at one of the large institutions and in another the Kiwanis Club was leading a community effort for the building of a chapel.

Worship services and religious instruction —

5. a.

QUESTION NO. INSTITUTIONS

Do you have regularly scheduled services of worship on the Sabbath	Yes	<u>83</u>
	No	<u>5</u>
	No ans.	<u>6</u>

A large number of Institutions conduct more than on service; the greatest number having two, but in some cases three or more. Attendance varied from 40 to 1200. These figures a low of 9% to a high of 100% in five institutions. The average was 37%.

(Includes only those institutions giving clearly defined figures.)

b.

QUESTION NO. INSTITUTIONS

Do you have an adult choir?	Yes	<u>66</u>
	No	<u>23</u>
	No ans.	<u>5</u>
Is choir robed ?	Yes	<u>41</u>
	No	<u>45</u>
	No ans.	<u>3</u>

c.

QUESTION NO. INSTITUTIONS

Do you have a children's choir?	Yes	<u>36</u>
	No	<u>50</u>
	No ans.	<u>8</u>
Is choir robed ?	Yes	<u>14</u>
	No	<u>21</u>
	No ans.	<u>51</u>

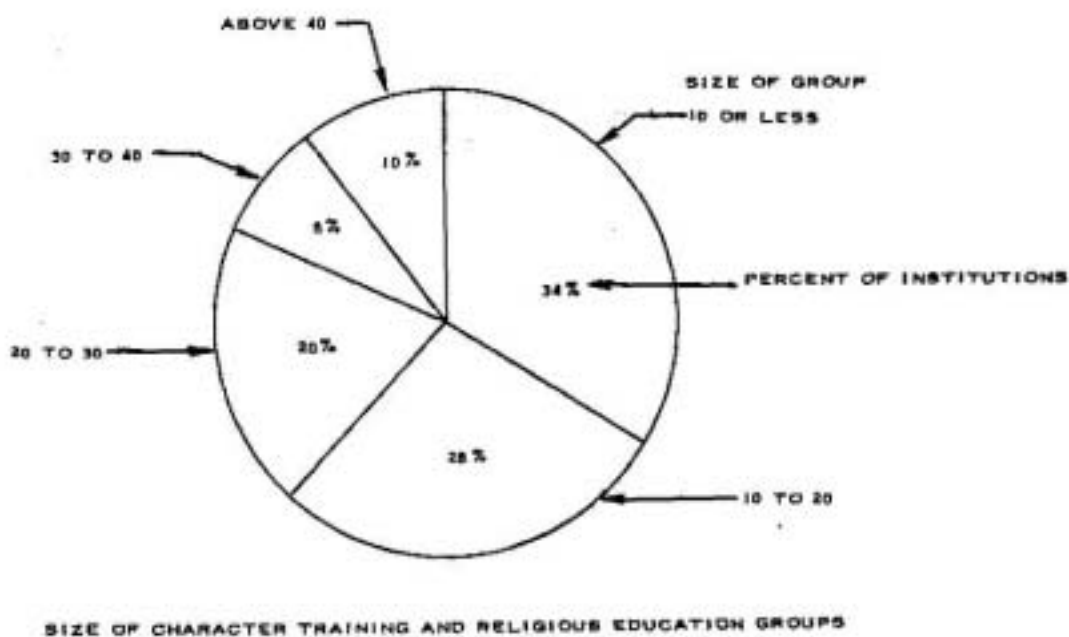
Size of the choirs varied from 10 to 50. One questionnaire reported a quartette; another; "They all sing". Some with almost no formal program had a choir; others with many activities had no choirs.

6. a.

QUESTION NO. INSTITUTIONS

Do you have regularly-scheduled small group sessions for character training or religious education study ?	Yes	<u>72</u>
	No	<u>17</u>
	No ans	<u>5</u>

Approximately 80% of all institutions have a program of instruction. Time of day that meetings are held is divided about equally between morning, afternoon and evening, with a smaller number mentioning Sunday specifically — this in addition to the formal worship service. Several mentioned bi-weekly classes and 3 indicated daily classes for short periods of time on an annual basis.



Size of groups varied greatly though more than half (58%) had groups of 20 or less. The average size group numbered 23 but this was due to 3 exceedingly large groups numbering 60, 78 and 150. The chart indicates the percentage of institutions having various sized groups. It will be noted that 38% have classes with more than 20.

b.

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QUESTION	NO. INSTITUTIONS
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Are the teachers who work in these sessions given special instruction in working with and teaching retardates ?	Yes <u>58</u>
	No <u>30</u>
	No ans. <u>6</u>

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By whom is such instruction given?

A number indicated that the Chaplain did all the training of teachers; others assisting in the training of teachers were: a Professor of Humanics, a Recreation Director, Social Worker, Psychologists, members of the State Department responsible for the retarded, outside volunteers and members of the professional staff.

7.

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QUESTION	NO. INSTITUTIONS
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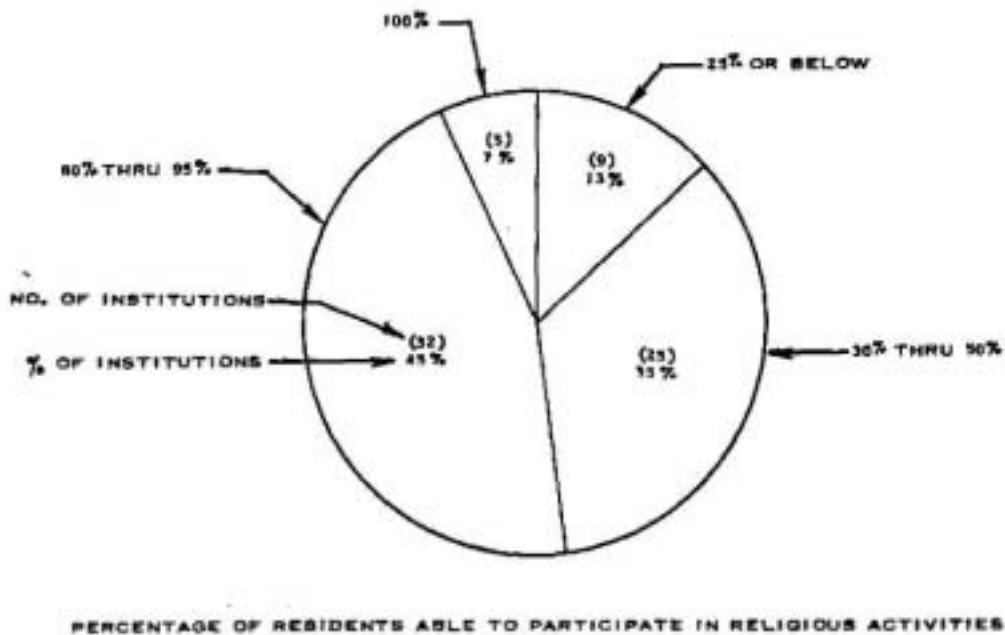
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Do you make use of volunteer help in your total religious education program ?	As teachers <u>63</u>
	Musicians <u>47</u>
	Other ways <u>17</u>

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Some of the additional ways in which volunteers were used to aid in the religious education program were: arranging the altar; as god-parents; clerical work for Chaplain; helping with social events; transporting retardates to churches in community for special services.

- 8.a. Approximately what percentage of the total enrollment of your institution is able to participate in one way or another in the religious activities as they now exist? (This would include on-the-ward activities for severely retarded as well as formal programs planned for the moderately and mildly retarded.)



Percentages of participation varied from a low of 10% in two institutions for the severely retarded to 100% in five institutions. In almost half of the institutions 50% or less of the population participated in some form of religious program.

b.

QUESTION	NO. INSTITUTIONS
Do you have definite plans underway for expanding the spiritual ministry to the residents of your institution?	Yes <u>48</u> No <u>37</u> No ans. <u>2</u>

Three of those institutions with 100% participation indicated they would like to expand their program of spiritual ministry; two desired better ward programs and one would send all residents to local churches. Some of the other plans for expansion of programs included:

€ Plans to improve ward services	12
€ Making requests for full-time Chaplains	7
€ Increase staff	9
€ Improve program for residents leaving ins.	3
€ Specifically requesting more volunteer service	17
€ Planning to host a clinical training program for pastors	3
€ Need for more adequate worship facilities	50

9. Please describe briefly any spiritual ministry you are able to give to the very severely retarded who are confined almost totally to their wards or cottages.

17 made no reply to this question: 5 indicated this did not apply to their institutions as they did not have severely retarded residents. 22 indicated they allowed visits, but they did not indicate by whom or how often. 12 indicated the administering of sacraments with one reporting Mass 4 times yearly. 22 reported the use of music with the severely retarded on wards; singing by special groups, action songs, records and hymn singing were mentioned. 12 reported Bible stories as being useful. Other means of working with the severely retarded were: prayers, filmstrips, movies, pictures of Jesus, simple worship services, tapes, flannel-graphs, radio broadcasts, sick visits, drawing and coloring.

10. How does religious worship and character training play an integral part in the total programming for institutionalized retardates?

Answers to this question indicated two interpretations to the question: one set of replies showed how the religious program was part of the team approach in planning and execution along with recreation, education, therapies, etc; the other set of replies listed benefits to the individual retardate. The larger number interpreted the question as applying to the individual residents and answered accordingly.



## I. INTRODUCTION

In a country such as ours which subscribes to a philosophy that recognizes the dignity of the individual and his inherent worth in the sight of God, the need of religious education for the mentally retarded is imperative as an integral part of their total development. The fact that the retarded individual happens to live in a residential center in no way lessens his need for religious nurture. And, although progress is slow, there are many indications that interest in providing religious education for the retarded is definitely on the increase, both within the community and in State residential centers. One evidence of this increasing interest has been the significant numbers of articles relating to religious education for the retarded which have appeared in national and international magazines and Journals within the past several years. Several books have been published relating to this specific need, and in addition, a limited amount of curriculum material has been developed for use in teaching religious concepts to the retarded. At the present time, two of the largest Protestant denominations have their Commission on Christian Education studying this overall need with the aim in view of developing further curriculum material in this field .

In an effort to determine the scope of existing programs and future planning for the religious education of retardates in State residential centers, the Committee on Residential Care of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN made this a part of a broad, comprehensive study of tax-supported institutions for the retarded throughout the United States. One hundred and eleven centers received the survey questionnaire on religious education for the retarded. Ninety-four of the institutions responded. The data acquired, a discussion of the results of the analysis of the data and some general recommendations from the Committee are presented in this report.

**A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED  
IN THE UNITED STATES**

By THE NARC COMMITTEE ON RESIDENTIAL CARE

PART VII. RELIGIOUS NURTURE

Comments such as the following were recorded by the persons who explained the mechanics of their program in relation to the over-all institutional program:

- "We try to do as child would at home, grace, bed-time prayers, observance of religious holidays, etc,"
- "Integral part of our programming-Chaplain member of clinical team."
- "Very important in total program-parents and guardians are greatly concerned."
- "Major factor in total care program; Chaplain attends all staff meetings."

It must be noted here, however, that there was a very small minority which was less than enthusiastic about the program. One questionnaire answered that the total program would suffer if more than one service were scheduled. Another said: "No special emphasis has been placed on the religious program other than of the Catholic residents in preparing them for First Communion and Confirmation."

Those commenting on the program in its relationship to the individual retardate had the following to say:

- "Good basic religious program will help in everyday living in truthfulness, cleanliness and obedience."
- "Makes cottage living more harmonious; more tolerance for fellowman."
- "Gives them comfort and guidance, develops emotional health."
- "Helps them accept their handicaps better."
- "Teaches reverence, tolerance and to live with others."
- "Conveys decency, honesty and proper behavior; stimulates interest in things that really count. "
- "Gives feeling of security, faith and hope become part of their lives; others might have failed them but not God."
- "These are individuals of worth and dignity-they are aware of a Heavenly Father."

- "Gives residents something to look forward to each week; it provides a reason for dressing up, it entertains, it gives security."
- " Helps deepen appreciation for religious principles, gives experience in participating in worship, helps poise and self confidence; also helps to familiarize with the Holy Scriptures."

### III. DISCUSSION

The fact that the overwhelming majority of institutions (88 out of 94 reporting (q. 1a.)) make some effort at religious nurture for their residents presents conclusive evidence that administrators consider this to be a worthwhile aspect of their total program. Further evidence of the value placed on this program is the fact that 88 institutions employ full or part-time Chaplains, and that the salaries of 79 of these are paid by the State. (q. 2a, b.)

#### Views of Authorities

In addition to the study of the statistical data obtained from the institutions, members of the NARC Committee on Residential Care also read extensively in the professional literature related to the religious nurture of the retarded. This was done in order to obtain the opinion of a number of recognized authorities in the field of mental retardation, Morris and Miriam Pollock said of religious training in their book, New Hope for the Retarded:<sup>1</sup>

"The mentally retarded are capable of religious devotion... These children often have a more positive feeling toward an all-protecting God than does the average youngster. They take for granted the Lord's goodness... Religion gives these children a richer life."

Sigurd Peterson, Chaplain of the Parsons State Hospital and Training Center, states in the introduction of his book, Retarded Children: God's Children:<sup>2</sup>

"The underlying thesis of this book is that these children are persons who can respond in meaningful ways, and therefore, we must conceive of them in terms of human values and divine purposes."

Perhaps no one person in the country can speak with more authority of the value of religion to a retarded child than Sister Mary Theodore, O.S.F., from the St. Colletta School in Wisconsin. Sister Mary has given her life to work with the mentally retarded and out of her years of rich experience

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1. Pollock, Morris P. and Miriam, New Hope for the Retarded. Porter Sargent Co., Boston: 1953.
  2. Peterson, Sigurd, Retarded Children: God's Children. Westminster Press, Philadelphia: 1960.

she writes:<sup>3</sup>

"The value of religious care for mentally retarded children can be measured only by the value of an immortal soul. Each handicapped child possesses the inherent dignity of a human being. Because of his super-natural destiny, he is a citizen of two worlds. In this world his limitations mark him as under privileged, but in the world of the spirit he is the loved child of a Heavenly Father. Most important (to the child) is the moral sense inculcated by Christian parents to whom God's law is the law of life. For the retarded child, ideas of what is really significant in life are caught rather than taught. Basic traits, such as unselfishness, respect for authority, a sense of modesty, and reverence for holy things reflect the parents' values. When the foundation of character is laid in a good home, the child with mental retardation is more amenable to formal training. Love and security expressed in conscientious home care enables a retarded child to make the best adjustment in a residential school if placement becomes necessary. When faith has been implanted in early life, it finds expression later on."

Reverend Merlin W. Zier, Superintendent of the Wheatridge State School in Colorado, (formerly Chaplain at the Rainier State School, Washington), wrote this about the program for the religious nurture of the retarded:<sup>4</sup>

"The interest displayed by the residents of Rainier School is exceptional. Although the entire program is voluntary, nearly all of those who are in a position to exercise their desire attend either Protestant or Catholic services. Our children have feelings and attitudes the same as and often more acute than others. The retarded child is not immune from an ethical, moral or religious judgment at his own level."

From the opinion expressed by the authorities who studied the problems of mental retardation at the 1960 White House Conference on Children and

3. . "Some Fragments Are Gray," Columbia (magazine) August, 1962.

4. From newsletter, "Hope for Retarded Children". Washington Association for Retarded Children, Seattle: April, 1960.

Youth: <sup>5</sup>

"We must create in the institution and the community a climate of understanding and acceptance of the mentally handicapped as children of God, citizens of the world, members of a family and a community with the basic rights and integrity of all individuals."

#### Account of One Specific Program and Its Results

Perhaps the most concrete way in which to interpret the value of religious programs in institutions for the retarded is to give a word picture of one such program. The religious emphasis at the Dr. Joseph H. Ladd School, Rhode Island, is under the direction of the School's Education Director, Mr. Francis P. Kelley.\* Says Mr. Kelley: "As we provide for the physical, emotional and social needs of our boys and girls, we recognize the fact that we must not neglect the spiritual needs of the children." The program is for "all who can benefit" — that includes all of the educable and trainable children and some of the severely retarded group. Of the 925 residents at the School, 490 are enrolled in the religious instruction program. There are 300 in the Roman Catholic group, 135 in the Protestant group, 30 in the Jewish group and 25 in the Episcopal group. Four part-time Chaplains assist with the program — a Baptist, Minister, a Jewish Rabbi, a Catholic Priest, and an Episcopal Minister. The following excerpts are from an article by Charles E. Clark, Reporter for the Journal-Bulletin, one of Rhode Island's leading newspapers:

"Because religion has proved to have a therapeutic value on the mentally retarded — and for deeper, more philosophical reasons as well — the school is still studying the program to see whether even more should be included. Religion at the Ladd School, much more than a perfunctory visiting chaplaincy program, is not on a level that needs the explanations of a John Calvin, a Reinhold Niebuhr or a Thomas Aquinas.

It is better seen, rather, in the awkwardly clasped hands of a teenaged boy as he reverently leaves the school's big new auditorium after Mass. Or in the fervent, almost painful attempts to chant the ancient Hebrew prayers on key. Or in the low-bowed heads — which one can almost feel straining

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5. 1860 White House Conference on Children and Youth: Recommendations Concerning the Mentally Handicapped. (Available from NARC.)

\* Mr. Kelley is now Superintendent at Mansfield State School, Connecticut.

to comprehend the mystery of what is being enacted — during an Episcopal Communion service. Or in the painstaking care with which a man in his 40's during one of Mr. Elliott's mid-week "Sunday" School classes, colors a picture of Jesus...

'Primarily what we are doing', says Rabbi Goldin, 'is to excite the spark of the divine that is in them. They have faith. It isn't a blind faith, but it is faith without a doubt.'

'To most sophisticated adults,' Rabbi Goldin continued, 'God frequently is a last resort. To retarded children who have been schooled in their respective religious faiths, He is a first resort.'

'The fact that God loves everyone impresses them so very much,' added Father Davey. Each of the four Chaplains uses a unique approach and his own methods in putting the message of Divine Love across to the youngsters.

Aside from the spiritual enrichment that the program obviously has brought to both children and to the participating Chaplains, school authorities feel there is also a curative value in religious instruction and spiritual guidance.

The Chaplains, for one thing, are not viewed as authoritative, disciplinary figures, but rather as friends in whom children are quick to trust and confide... Individual attention is difficult to give in an institution and, according to the school clinical psychologist, is the one thing that is most necessary. The children get it from the Chaplains, he says, and in so doing get a 'feeling of self-respect and a feeling of being cared for'. He thinks the program also has an effect, admittedly not measurable, on their behaviour — such as the down-to-earth results reflected in the spontaneous command issued by one of the older of Rabbi Goldin's charges after a recent prayer service: 'All right now, no more swearing!'" <sup>6</sup>

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6. Clark, Charles E. "Their Parishoners are Forever Children," Journal Bulletin (newspaper)



The opinions of the authorities concerning religious education for the mentally retarded can be summed up in one terse statement from Reverend Bert Streufert, Chaplain of the Faribault State School and Hospital, Minnesota, When asked why he considered religious training a necessary part of the total program in the institution, he promptly replied: "For the same reasons you consider religious education important for your normal children at home."

### Concepts of Teaching

At this point perhaps there should be a brief look at concepts of religious teaching. For some people it is simply teaching a Golden Rule way of life, a do-good attitude that makes for greater happiness for all. For others, it is teaching a specific denominational creed with emphasis on sacraments, Holy Days, fasts and feasts, all of which are important to their faiths. Between these extremes are those who would teach some formal worship coupled with a charitable attitude toward all mankind. All three groups must be respected. All three groups abide by the basic belief in a Supreme Being and in the dignity of each individual person, no matter what his inherent intelligence. Information obtained from the questionnaires indicated that in the majority of cases the same facilities were used by all three of the major faiths in serving the needs of those residing in the institution. There was no indication that this presented any real problem, although the concepts of teaching were basically different for each faith.

### Chapels

When one considers how important church buildings are to all faiths, how beautiful surroundings inspire adoration and how a center of worship attracts and creates reverence in those who would worship, it is somewhat surprising that there are so few chapels in our institutions for the retarded. (Only 17 centers of the 94 replying have chapels. (q. 4a.)) However, it was most encouraging to note that 41 institutions have plans for a chapel in their future expansion. (q. 4b.) It was interesting to note that in one case an Association for Retarded Children was responsible for getting a chapel built; and in another case the Kiwanis Club led in a community effort to obtain a chapel. The fact that two outside or community groups were assuming the responsibility for building chapels may possibly indicate a trend or pattern that will be extended further in the coming years.

Although one report mentioned that fixtures and lighting reflect beauty to enhance religious worship, there appeared to be a lack of emphasis on

the use of color, music, etc., as tangible aids useful in making a beautiful and inspiring worship setting. The daily living conditions and surroundings of the institutionalized retardates must of economic necessity be functional. In too many cases they are not only functional but drab and ugly. This, then, provides all the more reason why every effort should be made to provide them with church buildings that are beautiful as well as inspirational. One such chapel, built specifically for the retarded, was the dream of Reverend Luther Holloway, a former Chaplain at the Austin State School in Texas. Reverend Holloway wanted the residents to have a place of worship "that would be the most beautiful thing in their lives." His dream was realized by a skylighted cathedral, 52 feet high, set off by stained glass windows on which there is an abstract design of some 100 gold birds flying in a turquoise sky, symbolizing the spirit of the children at the school. A gift from the people of Texas to the Austin State School, the chapel is used by all three faiths. This chapel is also used daily by the parents who come to the school to visit the children. Open all of the time, it is a place of quiet refuge into which parents can take their children.

#### Responsibility of Family to Religious Nurture

This brings us to another factor which the NARC Committee on Residential Care believes to be of vital importance in the religious nurture of the child in an institution: the responsibility of the family itself in helping to preserve for the retarded individual the inherent traditions, beliefs and customs of his own individual religious faith. The institution can and should provide an appropriate setting for worship and for programs of religious education. The institution can never serve, however, as a substitute for the family in interpreting to their child the religious beliefs and customs which are inherently their own. This is basically a family responsibility and as such should be accepted by the family as part of their over-all obligation to their child. For this reason we believe it is of particular importance and significance for retardates to be with their families to participate in their particular religious rites and observances.

#### Use of Volunteers in Religious Program

Working in the religious education program appears to be one of the best ways in which to fit volunteers into the total institutional program. It should be emphasized here, however, that such volunteers should by all means have specific training which will enable them to use appropriate and acceptable methods in teaching and working with the mentally retarded.

Several reasons were given to indicate the value of using volunteers in the religious education program. Among them were the following: (q. 7.)

- gives the volunteer an opportunity to work directly with the retarded (this is good for the retarded as well as for the volunteer) .
- volunteers usually represent several different religious faiths and can aid the Chaplain in meeting the differing needs of the various faiths.
- use of volunteers enables Chaplain to plan for a larger number of individual classes in small units, thereby increasing the number of persons served, as well as increasing the quality of service.

#### Service to the Severely Retarded

Attempts to meet the needs of the severely retarded in wards and cottages are being made in a variety of ways, but replies to this inquiry (q. 9.) indicated that not much real success is apparent. Certainly, this is an area in which much work needs to be done. The importance of a close relationship between the Chaplain and the very limited child was stressed in a dozen reports. This aids in strengthening the child's sense of security and gives him a more tangible conception of a God who cares for him deeply. Several replies pointed out the value of counselling with parents of severely retarded children. One interesting report concerned weekly chapel services for the severely retarded conducted by trainable girls; another related how successful a Jewish Rabbi had been with Hebrew chants in the wards. A large number mentioned the use of music in their ministry to the severely retarded.

On the whole, this question was answered too briefly. It is evident, however, that attempts are being made to reach these children, even though the results may not be as obvious as with less handicapped individuals.

#### IV. CONCLUDING REMARKS

A thorough study of the questionnaires submitted to the institutions, a review of professional literature relating to religious education for the retarded, and personal interviews with staff people in numerous institutions have led the NARC Committee on Residential Care to the conclusion that the interest in religious nurture for the retarded in residential centers is definitely on the increase. Statistics relating to the building of chapels and employment of full-time Chaplains signify a decidedly increasing interest in this aspect of institutional care.

Fifty institutions indicated plans for expansion of their programs in religious education. Experimentation is underway to find more adequate ways in which to meet the needs of the severely retarded confined to wards and cottages. Although much has been done, much remains to be done. Plans for the future indicate that more volunteers will be used in the religious program. Although this is a healthy trend, it cannot be emphasized too strongly that such volunteers should be given specific training for such service. More harm than good often results when the mentally retarded are exposed to methods of teaching or religious philosophies which are not appropriate to their needs.

There is a definite need, too, for exploring methods for establishing a closer relationship between the family and the resident regarding his religious nurture. Families should be encouraged to take their child home for religious observances which are significant to their own faith. Parents must be helped to realize that the guidance of the religious life of each of their children, retarded or otherwise, is a family responsibility, and as such they have no right to expect the institution to assume complete responsibility for the religious welfare of their retarded children.

## V. RECOMMENDATIONS

1. Every State residential center for the retarded should have a full-time Chaplain.
2. Every State residential center for the retarded should have a chapel which can be used for worship services, for religious education programs and for other general assemblies of an appropriate nature.
3. Clinical training programs for Chaplains should include special study of the basic needs of the retarded, along with direct experience of working with the mentally retarded and their families.
4. Volunteers should be utilized in teaching religious classes and in all cases should receive special training.
5. Within reason, more attention should be given to meeting the needs of a particular faith, such as dietary requirements, attendance at special services, etc. Families, however, must at all times be encouraged to accept their inherent responsibility in these matters.
6. Opportunities should be provided for residents to visit in churches of the local community for worship, church school and activities of youth organizations.

VI. REFERENCES

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3. "Some Fragments are Gray," Columbia Magazine, Aug. 1962.
4. Hope for Retarded Children, Newsletter, Washington Association for Retarded Children, Seattle. April, 1960.
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A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED IN  
THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

**PART VIII. VOLUNTEER SERVICES**

## I. INTRODUCTION

Volunteers, per se, are not new in State residential centers for the mentally retarded. For many years, good hearted people, visited institutions in varying numbers and frequency depending upon the welcome extended by the administrators. With the advent of Associations for Retarded Children which stimulated public interest in the needs of the retarded, and with the development of an open-door policy along with a new concept of the role of the institution as a community facility, many administrators have come to recognize that volunteers can contribute much to the effectiveness of care and treatment programs. The role of the volunteer in gaining public support for needed improvements in residential care has also been recognized by the majority of administrators. Consequently, volunteer programs involving many more community people in a wide range of activities and services have begun to take shape in institutions for the retarded, just as they did in general and psychiatric hospitals throughout the country following World War II.

The NATIONAL ASSOCIATION FOR RETARDED CHILDREN is interested in volunteer services as one aspect of total programming in tax supported residential centers for the mentally retarded. It is interested in the present scope and development of programs and the implications for the future. For this reason, the NARC Committee on Residential Care chose to include a survey of the volunteer service programs as one part of a total survey on institutional programs and practices throughout the nation. A detailed questionnaire on the volunteer program was submitted to 111 tax supported residential centers. Replies were received from 93 institutions, representing 48 States. The literature on volunteer services was reviewed and interviews were held with some coordinators of volunteer services. The data, discussion, and recommendations presented in this section of the study are based on these resources and the information obtained from these questionnaires.



## II. BACKGROUND INFORMATION ON VOLUNTEER SERVICES

The following interpretation of the various types of volunteer programs is given as a background for the main body of this report.

The Illinois handbook, *HOW VOLUNTEERS WORK IN STATE HOSPITALS*,<sup>1</sup> lists three general areas of volunteer services as follows:

1. "Those who come from time to time in groups, or as representatives of groups to bring gifts or provide recreation and entertainment ...It is sometimes under the direction of the supervisor of volunteers, sometimes the hospital superintendent, and some times under recreational or occupational therapists .
2. The specialist or artist who comes to give a lecture, concert or some other type of performance.
3. Those persons trained by the hospital who undertake regular assignments in the over-all hospital program thus becoming an integral part of the hospital team. "

This third type of volunteer has an intimate part in the day-to-day hospital program. All are willing to undertake special training for the job. They agree to work a minimum of 100 hours a year and frequently work many more. The third type of volunteer is described further in the American Hospital Association Manual, *THE VOLUNTEER IN THE HOSPITAL*,<sup>2</sup> as: "the inservice volunteer who is assisting in a service function of the hospital, under staff supervision and direction; who is oriented and trained to give, directly or indirectly, supplemental service to patients. " For the most part the same types of volunteers (with modifications of type two) are also used in residential centers for the retarded. It should be noted that there are various types of community organizations involved in volunteer programs; they can be classified in a general way into four types:

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1. Sharp, Agnes A. How Volunteers Work in State Hospitals. Illinois Department of Public Welfare, Chicago: 1953.
  2. The Volunteer in the Hospital. American Hospital Association, Chicago Illinois: 1959.

1. Community groups or agencies whose first allegiance is to their own organization, and whose service to the institution is only one of many interests. Examples; church groups, womens' clubs, Red Cross, fraternal and civic organizations, college and youth groups.

2. Parent groups which may function as an auxiliary to the institution but most frequently are autonomous and are concerned with all the retarded rather than those at the institution alone. Many of these parent groups are members of the NATIONAL ASSOCIATION FOR RETARDED CHILDREN and as such are committed to work for all retarded children and adults wherever they may be found.

3. Councils of Volunteers. As the name implies, these are made up of volunteers serving at the institution. In most cases, the membership also includes representatives of various community organizations, and frequently includes prominent individual citizens who have given support to the program in some way.

4. Institution Auxiliaries. These are similar to the hospital auxiliary described in the American Hospital Association handbook<sup>2</sup> as: "An organized community group of women and/or men with no other purpose or obligation than service to its hospital. It operates under the guidance of the administrator. The hospital auxiliary is an integral part of the hospital family."

### III. DATA FROM QUESTIONNAIRE ON VOLUNTEER SERVICES

#### Section One: Organized Volunteer Services

Questions in this section of the questionnaire pertained to organized volunteer services where volunteers were recruited, screened, and trained by the institution to accept specific assignments and serve as an integral part of the institutional team.

#### Scope and direction of volunteer services

##### 1. a. QUESTION NO. INSTITUTIONS

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Is there someone responsible at the <u>State</u> level for coordinating and developing volunteer services in your State institutions ?	Yes	<u>34</u>
	No	<u>59</u>
	No ans.	<u>0</u>

---

According to information obtained from ROSTER OF DIRECTORS EMPLOYED BY STATE MENTAL HOSPITALS AND SCHOOLS,<sup>3</sup> six of these 34 are full-time employees of the State. Six were listed as part-time employees of the State. No information was given about the remaining 22.

- b. Question b. asked for the name and title of the person responsible for the volunteer programs at each institution. 41 named the Directors/Coordinators of Volunteer Activities; 23 named other staff persons responsible for volunteer programs. Among those named were: Superintendents, Assistant Administrators, Social Workers, Chaplain, Recreation Assistants, Directors of Training, Vocational Instructor, Physical Education Instructor, and Assistant Director of Nurses.

3. Roster: Directors of Volunteers Employed by State Mental Hospitals and Schools.  
National Association for Mental Health, New York: 1960.

c. QUESTION NO. INSTITUTIONS

Do you have a	Yes	<u>26</u>	The main responsibilities of most Staff Advisory Committees were reported to lay in the area of establishing policies and procedures for volunteers. Some of the responsibilities listed were to:
staff advisory-committee on	No	<u>60</u>	
volunteer services ?	No ans.	<u>7</u>	

- report on residents with special needs for volunteer services;
- assist in planning and orientation and training, and, in some cases, to help with in-service training;
- meet with volunteers or Volunteer Advisory Committee to discuss mutual problems and resolve any differences that might arise.

d.

QUESTION NO. INSTITUTIONS

Do you have a	Yes	<u>23</u>
volunteer	No	<u>64</u>
advisory	No ans.	<u>6</u>
committee ?		

Seven institutions reported that they have both a Staff Advisory Committee and a Volunteer Advisory Committee. Most of the Volunteer Advisory Committees were reported to be made up of representatives

of organized groups or councils of volunteers. In some cases the councils were comprised of representatives of many community groups; in others, the councils were made up of volunteers actively involved in the institutional program. Other organized groups mentioned were parent groups (Associations for Retarded Children), or auxiliary type groups connected with the institution. Comments indicated that the majority worked with the Volunteer Director, although several mentioned that the committee met with the institutional staff. The main functions of the Volunteer Advisory Committee were to:

- maintain liaison between the institution and the volunteers;
- discuss plans and problems relating to volunteer programs;
- assist in recruiting more volunteers;
- help plan and carry out special, large projects;
- interpret institutional policies to their own groups.

Further information given under question one revealed these statistics:

Number of institutions

64	Reported organized volunteer services.
6	Reported informal volunteer activities.
13	Reported no volunteer activities.

Expansion, recruitment and recognition

2. a.

QUESTION      NO. INSTITUTIONS

Do you have	Yes	<u>72</u>
plans to expand	No	<u>18</u>
your volunteer	No ans.	<u>3</u>
program?		

Reasons given for expansion:  
need more volunteers (39);  
to extend program or service  
new facility (29); to gain  
greater public understanding  
and public support (8);  
individual care for residents

in order to establish a one-to-one relationship between volunteer and . resident (5);  
to provide extras for residents (3); to promote research and to supplement  
professional services because of insufficient staff (4)

b. What is your most effective means of volunteer recruitment ?

<u>Method</u>	<u>Number of institutions</u>
Personal contact through staff or other satisfied volunteers:	<u>90</u>
Through community agencies:	<u>34</u>
Through news media:	<u>19</u>

These figures demonstrate that direct personal contact, through individuals or groups, is considered to be more effective than news media. It is also obvious from the manner in which the question was answered that a fairly broad, over-all approach is used by most persons responsible for development of volunteer programs. In addition to the methods named above, newsletters, bulletins, form letters and speakers were used in volunteer recruitment.

c.		INSTITUTIONS	
QUESTION	NO.		
Do you have some type of program or award system for recognizing the services rendered by your volunteers?	Yes	<u>55</u>	Recognition programs followed a fairly uniform pattern: awards were presented to individuals and/or groups, usually at annual meetings or social functions such as open house, luncheons, teas or dinners. American Hospital Ass'n or other similar pins were given. Groups usually received certificates.
	No	<u>32</u>	
	No ans.	<u>6</u>	

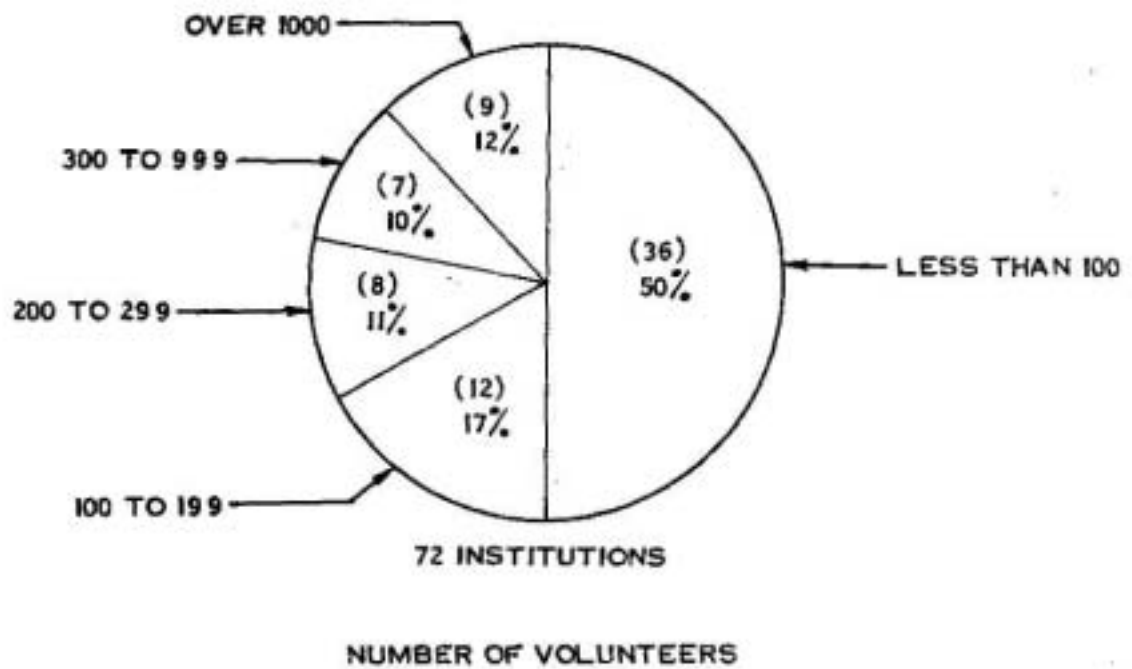
#### Areas and magnitude of volunteer services

3. a. Do your volunteers work directly with the residents in the following areas of service ?

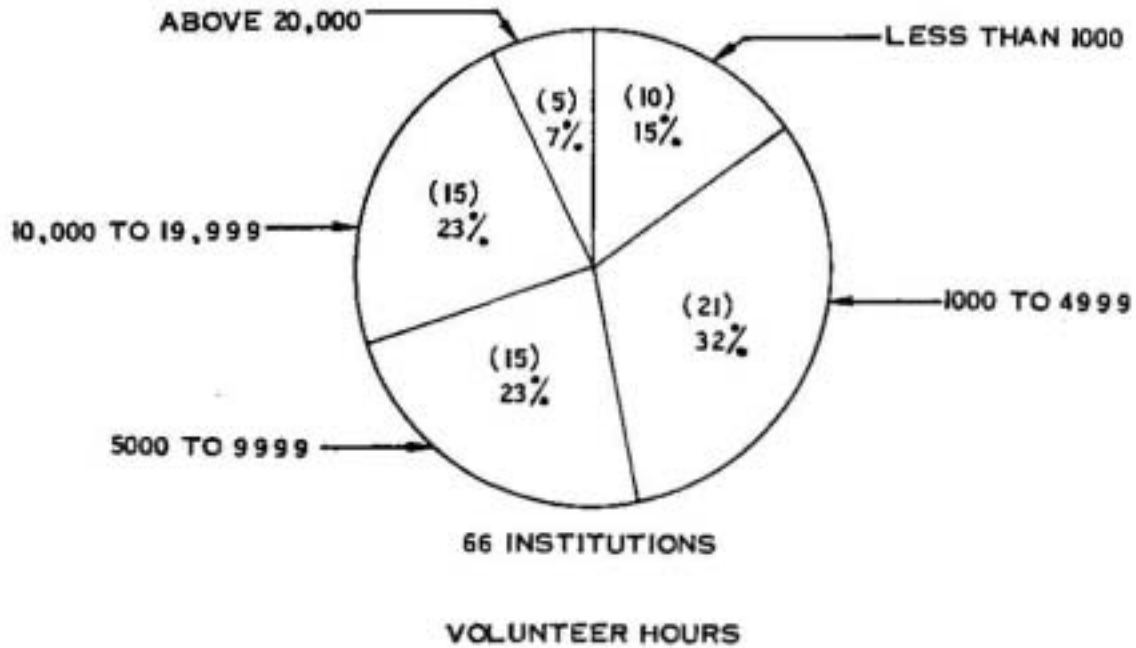
Recreation	<u>72</u>	Feeding	<u>39</u>
Education	<u>55</u>	Bathing	
Hospital Ward	<u>54</u>	Dressing	<u>1822</u>
Religious Training	<u>68</u>		

- b. Other areas of service listed in their approximate order of frequency: Receptionists, clerical, tour guides, hostesses, Library, sewing, Canteen, Clothing Store, Social Service, shopping, Psychology, parties, grooming, Beauty Shop, letter-writing, occupational therapy, Laboratory aides, speech therapy, landscaping and gardening, chaperones, cases aides, research, dramatics/stage-craft/costumes, 4-H Clubs, Scouts, "Adopt-a-Friend"/"Patient Pals"/ Big Brother-Sister, etc., transportation, craft programs.

c. What is the magnitude of your volunteer services ?



Many institutions indicated a need to keep better records on volunteer services. Half of those reporting had less than 100 volunteers. A total of 61,691 volunteers was reported.



Although most institutions stated their records were inadequate, a total of 492,872 volunteer hours per year was reported. Almost half of the institutions receive less than 5,000 volunteer service hours annually. This is the equivalent of less than two full-time workers.



Section Two: Informal Volunteer Services

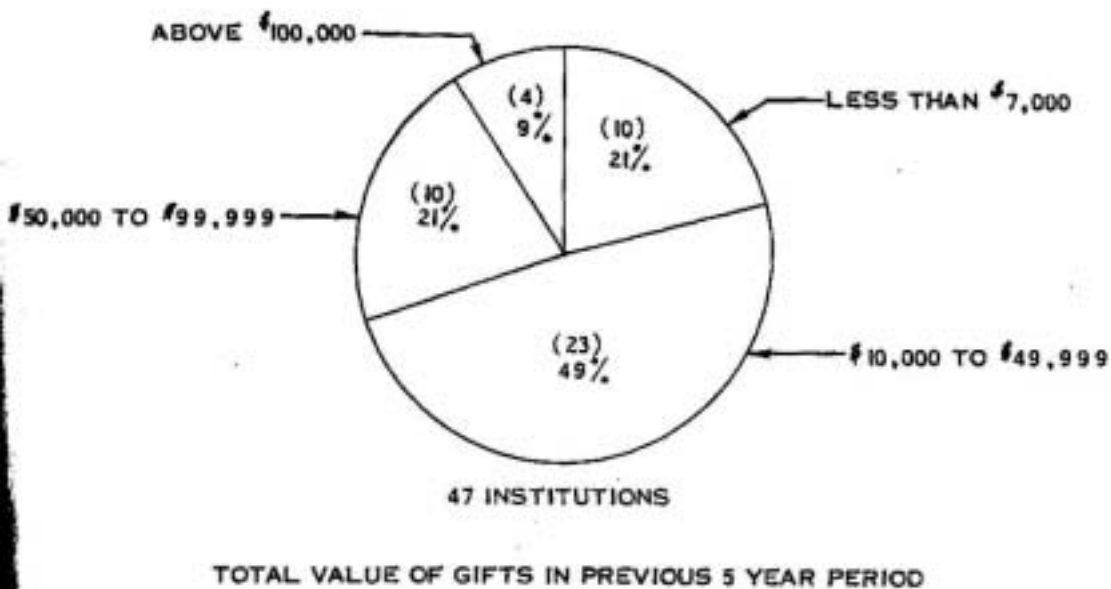
The questions and answers in this section dealt primarily with volunteer activity in behalf of the institution on the part of individuals and community groups that were not necessarily a part of the organized volunteer program.

4.

QUESTION	NO. INSTITUTIONS
Do you have a planned procedure for enlisting the interest and support of community groups throughout the State for your institution ?	Yes <u>54</u> No <u>25</u> No ans. <u>4</u>

The planned procedures reported closely paralleled the recruitment methods for obtaining individual volunteers, with the major emphasis falling on direct contacts with community organizations. Associations for Retarded Children, church groups, club groups and Mental Health Ass'n Chapters were mentioned frequently. Many replies indicated the use of speakers before such groups. Extensive and regular use of newsletters, bulletins and form letters was another common means of stimulating interest and gaining support. Several mentioned special programs involving public officials, with subsequent publicity as a means of centering favorable attention on the institution.

5. Please give the approximate value of tangible gifts made to your institution by volunteers (either groups or individuals) over the past five years. { This would include recreational equipment, training equipment, special furniture, anything bought for the institution aside from that purchased with tax funds provided by the State.)



Records were considerably inaccurate, but an estimated total value of \$2,824,847 in gifts and cash was given over the previous five year period.

6. a. What do you consider as some of the advantages to be gained by enlisting lay interest and support for your total institutional program ?

Answers to this question could be summarized thus:

Benefits to residents:

- Better over-all program; "stimulates residents", "keeps residents in touch with everyday life.
- Meets emotional needs of residents by helping provide the important "one-to-one" relationship.
- Provides bridge to the community for residents who may be discharged.
- Provides personal extras such as gifts, clothing, etc. for the neglected or indigent resident.
- Promotes "better family acceptance"; "helps to promote more realistic picture of program of the institution to parents of potential patients"; also, when residents become important to volunteers who work with them they are far more likely to assume a greater importance in the family constellation.

Public relations benefit:

- Develops community awareness, acceptance and understanding of the total problem of mental retardation.
- Develops public support of institutional programs, especially in the area of needed legislation. One administrator commented thus: "Major improvements at the institution are accomplished by bond issues. We have been fortunate to receive two bond issues, one for \$1,750,000 and one for \$2,700,000 over the past five years. This was possible because of public interest in the school. "Another stated: "A better informed public sees the need for improving State institutions and will provide the funds. In 1958 a public welfare bond issue was defeated; in 1960 after two years of intensive publicity and contacts with PTA, civic clubs and churches, the bond issue was passed."

Material benefit:

- Volunteers supply many of the material "extras" not included in the institution budget; this makes for a much richer and more varied program than could otherwise be offered.

Benefit to staff:

- Supplies help for staff to carry out more effective programs.
- Motivates staff; "gives employees a feeling of belonging to the community", an increased pride in their place of employment.
- "Helps staff achieve goals and instills pride when goals are achieved."
- "Keeps personnel on their toes."

- b. What do you envision as some risks or disadvantages? (In volunteer programs.)

Disadvantages to residents:

- "Over-dependence on volunteers to the detriment of regular employees."
- Disruption or failure of program because of unreliable volunteers; emotional involvements of volunteers with residents; "over-sympathetic volunteers (who) will not adhere to rules"; "untrained volunteers who could cause accidents or discipline problems"; unintentional errors by "eager beavers" often cause problems.
- Possible physical harm to volunteer; possible physical harm to resident. (Sexual assault was named here as a possibility.)

Disadvantages in public relations:

- Interference by pressure group; "vested interest groups with dictatorial attitudes regarding program and policies could resist change and hinder developments."
- Misinterpretation of institutional needs and program: unintentionally, because of superficial or assumed knowledge, or deliberately, if volunteer is dissatisfied; when the latter happens an appeal is often made so that the "public will have a feeling of sympathy rather than understanding for the residents."

Disadvantages to staff:

- Staff resentment: "Conflict between volunteer and staff that doesn't come to the attention of the administrator"; "Neurotic volunteers can upset relations with staff"; "Some employees may feel the volunteer is a possible threat to their job, but

- this will lessen as a better understanding develops";  
"Occasionally, the 'public' takes a 'busy-body' attitude instead of a concerned one and this is irritating and threatening to staff".
- Cost: "prohibitive expense to supervise"; "Takes staff time to supervise".

The summaries presented obviously do not include each advantage and disadvantage or risk exactly as stated but they represent a fair cross-section. The advantages enumerated outnumbered (and outweighed) the disadvantages and/or risks. While almost all of the replies listed advantages, many replies stated "no disadvantages" or minimal risks, and many listed possible risks but stated that proper management of the program with careful screening, proper orientation, training and supervision would eliminate these. An interesting contrast was presented by replies from two institutions with very limited volunteer programs and the reply from an institution with a well organized-program. The first two reported "prohibitive expense of supervision" and "takes staff time to supervise". The third reported: "A better informed public sees the need of improving State institutions and will provide the funds". This same institution reported tangible gifts of \$104,250 received over the past five years.

7. In your opinion, what are several specific ways in which the lay public in general (both individuals and groups) could best serve your total institutional program?

The "several specific ways" added up to about two hundred suggestions. As with the replies to the question on advantages, recurring ideas created a pattern that was very similar to the list of advantages. For example, there were many suggestions that the public be stimulated to become better informed on mental retardation, and the institution and its needs which in turn would provide support for programs and legislative action. Additional noteworthy suggestions were:

- Provide help or support for the mentally retarded who return to the community from the institution; help find or provide lodging, recreation facilities, jobs, rehabilitation services, etc.
- Provide funds for institution equipment and facilities not

provided by limited State funds.

- Help expand volunteer services by serving as volunteers or recruiting others for service in all areas, and especially to give residents individual attention, to help them feel self-worth, to get them out of the institution for visits, tours, shopping, etc.

Among some of the more unusual suggestions were these:

- "Help create desirable image of institutional employment."
- "Provide an enrichment program for higher functioning students which is not possible through routine operations of the school."
- "Get help from unions in our placement program, by having various unions accept our residents as apprentices."

It is impossible to do justice to the complete list of suggestions for volunteer service that were contained in the questionnaire. This sample, should, however, provide a stimulus and challenge to those who seek ways to use, and ways to give, volunteer service to the mentally retarded residents of State supported residential centers.

#### IV. DISCUSSION

##### Organization of Volunteer Services

The results of this survey indicate that volunteer programs are on the increase: that there are more volunteers being used in both informal and organized programs, and that they are being utilized in almost every area of programming for the mentally retarded in State residential centers. The increase in the numbers of volunteers and the acceptance of a new concept of the role of the volunteer as an integral part of the institution team naturally requires a more precise management of volunteers. It appears that an increasing number of institutions are moving in this direction. With 41 institutions out of 93 naming full-time Directors/ Coordinators of volunteer services and with 72 institutions out of 93 indicating plans for expansion of their volunteer services program, it becomes apparent that the majority of administrators recognize the value of a carefully planned and executed volunteer program. (q. 1d.; 2a .)

Answers to the questions in relation to advisory committees, recruitment, areas of service, etc., indicated that the organized programs are in different stages of development. Comments on many questionnaires drew attention to the fact that the programs were new or had only recently been organized under the direction of a full-time director. This may be the reason for the fact that so few of the institutions have a staff advisory committee on volunteer services - only 26 out of the 93 institutions queried. (q.lc.) If the volunteer program is to prove successful as an integral part of the total institutional program, it is imperative that the advice and counsel of staff members be utilized to the fullest. A close working relationship between staff members and volunteers under the guidance of a capable director will in most cases eliminate many of the problems that were pointed out as disadvantages in utilizing volunteers. (q. 6b.) Just as with the staff advisory committees, only about half of the institutions which reported having organized volunteer programs had volunteer advisory committees. (q.1d.) Here again, it becomes apparent that there is a real need for closer cooperation between institutional personnel and volunteer personnel in order that each might more clearly understand the duties, privileges, opportunities and obligations of the other. Such cooperation would no doubt eliminate the reason for this terse complaint from one member of an institutional staff: "Ignorant and/or arrogant 'do-gooders' can easily wreck a worthwhile program". It was interesting to note that a number of the institutions which have no volunteers or very limited volunteer programs were far

more concerned about the risks and disadvantages than those having organized programs. Those having well-organized programs indicated, in many cases, certain pitfalls that could possibly develop; all emphasized however, that these could be avoided or minimized with proper management.

Although the question was not asked on the questionnaire, 15 replies indicated that their organized volunteer programs were new. These, plus programs in nine institutions established since 1957, made up almost half of the present number of organized volunteer programs. It is obvious, then, that the last five years has been an era of steady growth in this field. Comments by three of the 13 who reported no volunteer activity at the time of the survey indicated that programs were being set up or planned, so there are indications that growth will continue. It should be noted too that some volunteer activities are carried on at two of the institutions which reported "no volunteers". One of these is a limited program carried on by members of Alcoholics Anonymous in a specialized facility for defective delinquents. The other reported: "We rely on our off-duty folk".

Among the numerous reasons given for the expansion of volunteer services was "insufficient staff". (q.2a.) One note of caution is in order at this point. The implication appears to be that volunteers can be used as a substitute for staff members, rather than a supplement. Volunteer services are only intended to supplement staff and employee services, not to replace them. When the volunteer is expected to serve in lieu of a paid employee the entire concept of volunteer work is destroyed and in most cases the individual volunteer feels no compulsion to continue working in such a situation. Securing adequate funds for institutional operation will be far more difficult if it appears that staff positions can be cut because there are volunteers to do the job. This is a vitally important factor and one which should not be overlooked when setting up programs of volunteer service.

#### Scope of volunteer services

Unfortunately, questions pertaining to the number of volunteers, the number of volunteer hours of service given and the actual value of tangible gifts over the past five years, were too ambiguous to elicit conclusive information. Records of the actual value of tangible gifts appear to be, for the most part, sketchy, incomplete or nonexistent. Although the answers were incomplete, it appears from the replies which were specific that volunteer service programs are valuable both on an intangible as well as a tangible level. With approximately \$2,824, 847 having been contributed to purchase items not supplied by tax funds (q.5) within the past five years, one readily



arrives at the conclusion that living conditions for retardates in residential care has been brightened considerably by those volunteers who are concerned for their material welfare. The fact, too, that some 61,691 volunteers contributed an average of 492,872 hours per year in direct service to the institutions stands as eloquent evidence that residents of these centers need no longer be considered as the world's "forgotten children". (q.3c.)

The wide variety of services reported is a good indication that there is almost no area where volunteers are not being used if the volunteer programs are well developed and coordinated. This question was asked as a part of the section dealing specifically with organized programs, but it was also answered in many instances by those who had only informal activities. The extensive use of volunteers (in both organized and informal programs) was especially noticeable in the areas of religious education and recreation. Both areas are naturals for volunteer participation. Many recreational activities such as parties, picnics, entertainments, etc., can be carried out with a minimum of supervision from Staff. Religious groups are noted for their service wherever there is a need and in a number of instances the entire religious program of the institution was carried out with the help of volunteers working with the Chaplain.

#### Advantages Gained from Volunteer Services

The vast majority of questionnaires, including some with no volunteers at all, reported advantages to be gained through volunteer services. Most of these emphasized as major gains: better public understanding of mental retardation, the institution, its residents and programs; supplemental service and material extras for the institution programs and residents; support for needed legislation; motivation of staff and benefits for residents. Under benefits to residents there were frequent comments that volunteers fulfilled emotional needs of the residents by providing individual personal attention as well as material extras for those residents who otherwise would be deprived of the commonly accepted small luxuries that make life more livable.

The varied and thought provoking list of suggestions for ways the lay public can best serve the institutions was revealing and challenging. There is ample evidence that much effort is being made by a large number of administrators to develop volunteer service programs that will live up to their names and fulfill their newly developing roles as contributing members of the total institutional team.

## V. CONCLUDING REMARKS

With 70 out of 93 institutions reporting volunteer activity of some sort, (q.1d.) and 64 of the 70 embarked on organized volunteer service programs, it appears that today, volunteer services are generally accepted as part of the total programming for the mentally retarded in State supported residential centers. This is further borne out by the fact that approximately one-third of the State departments charged with responsibility for these centers consider volunteer programs important enough to have assigned someone in the department to develop and coordinate them. (q.1a.) The data further reveals that nine of the eleven answering institutions established since 1957 have organized volunteer programs. This would seem to indicate that volunteer programs had the approval of the State departments involved, even though four of these same States do not have volunteer directors or coordinators. Evidence was presented which indicated that almost half of the present number of organized volunteer programs have been developed within the past five years. The substantial number indicating plans for expansion of present programs and the number indicating plans for the development of new programs prove that the present trend of growth will continue.

Discrepancies, comments, and the general tone of some replies, coupled with the information supplied (or omitted), leads one to suspect that there is confusion in the minds of many as to what constitutes an organized volunteer services program. Apparently, some institutional personnel make little or no distinction between informal volunteer activities and organized services; these appear to believe that substantial numbers of volunteers alone make a good volunteer program. It is possible that this has come about because the term "volunteer" has been loosely applied in the past to almost anyone who has given any kind of gift or service, and it is now being just as loosely bandied about in reference to volunteer services, regardless of kind. Whatever the cause, it is to be hoped that this confusion is overcome before any real harm is done to what promises to be a bright new facet of programming for the mentally retarded residents of State supported residential centers. Hartford<sup>4</sup> has summed up the "why" and "how" of developing volunteer programs, thusly;

"An informed public gradually becomes an interested public; an interested public then becomes an aroused

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4. Hartford, Robert J. Parent Groups: Their Organization and Management for Volunteer Services. Fort Wayne State School, Fort Wayne, Indiana, 1961.

public... Administrative planning is the keystone to the success of the volunteer program.,. it requires the highest caliber professional to make the best use of volunteers."

## VI. RECOMMENDATIONS

1. Each State Department responsible for administration of residential centers for the mentally retarded should provide the resource and consultant service of a specialist in volunteer services.
2. Every State residential center for the mentally retarded should have a Director or Coordinator of Volunteer Services. Several small, highly specialized residential facilities might well be served through the volunteer program of a community welfare council.
3. An orientation and training program should be provided for all volunteers,
4. In-service training for staff members should include preparation for working with volunteers as a part of the team.
5. Organized volunteer programs should have an Advisory Committee consisting of members of the staff in order that a closer working relationship be established between the volunteer efforts and the overall institutional program.
6. Volunteer services should be established as complementary and supplementary to staff, rather than as a substitute for staff.

## VII, REFERENCES

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A SURVEY AND STUDY OF  
STATE INSTITUTIONS FOR THE MENTALLY RETARDED IN  
THE UNITED STATES

By THE NARC COMMITTEE ON RESIDENTIAL CARE

**PART IX. REHABILITATION AND DISCHARGE TO COMMUNITY**

## I. INTRODUCTION

Historically, institutions were developed to provide relatively short term training and care for all but the more severely retarded. Their purpose was to equip the retarded with those skills which would enable them to return to their communities and adjust as quickly as possible to the demands of society.<sup>1</sup>

The nineteenth century philosophy (between 1850 - 1900) was to admit into institutions only those retarded who showed potential for social and occupational adjustment in the community. However, the institutions during this period of history never fully achieved their purpose because most of the residents admitted to these institutions remained for all or most of their lives. Only a small percentage of those accepted were later returned to the community on a self-supporting basis.

In 1919, Dr. Fernald completed one of the first follow-up studies of institutional parolees, dischargees, and runaways for Waverly, covering a period from 1890 to 1919. He discovered that many more retarded had a satisfactory social and occupational adjustment in the community than he had anticipated. Following his study and studies by others, there were greater efforts on behalf of institutions to place the retarded in the community.

Although most of the retarded reside in the community, today, the institutions are regarded as an essential part of total programming for the retarded. They provide residence and care for retarded who cannot be cared for advantageously in the community.

In the last decade some of the institutions have been gradually becoming modern centers for treatment, care and training; the purpose of these programs is to provide maximum development for retarded residents. Training and experience in most phases of living are offered: how to work, how to get along with others; how to utilize free time; and so forth. Some of these programs have developed as integral parts of the community.

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1. "A Manual on Program Development in Mental Retardation" Monograph Supplement to American Journal of Mental Deficiency, Vol. 66, No. 4, January, 1962.

Needless to say, education, training and rehabilitation programs may vary greatly among institutions. The Residential Care Committee thought it appropriate to identify those institutions with vocational rehabilitation programs and determine the current status of these programs. To achieve this end, a section of this study consisting of 18 questions on rehabilitation was included. Of the 111 institutions to which questionnaires were sent, 101 responded, 85 of the respondent institutions affirmed they conducted a vocational rehabilitation program.



## II. DATA FROM QUESTIONNAIRE ON VOCATIONAL REHABILITATION

### Personnel

1. QUESTION	NO. INSTITUTIONS	. QUESTION	NO. INSTITUTIONS
Is your vocational department administered by a trained vocational rehabilitation person?	Yes <u>33</u> No <u>52</u> No ans. <u>16</u>	Do you have full-time staff employees?	Yes <u>48</u> No <u>43</u> No ans. <u>10</u>

QUESTION	NO. FULL-TIME EMPLOYEES	NO. INSTITUTIONS
How many are employed full-time on your staff?	55 46 32 23 22 21 17 13 12 11 9 8 7 6 5 4 3 2 1	1 1 1 1 1. 2 2 2 2 1 2 1 1 2 4 5 5 7 7 Total Number of Institutions 48 Range 1-55

4. a. QUESTION NO. INSTITUTIONS

b. QUESTION NO. INSTITUTIONS

Does the State	Yes	<u>37</u>	Are they full-	Full-time	<u>8</u>
provide a counselor			time or part-time ?	Part-time	<u>29</u>
for your program ?	No	<u>43</u>			
	No ans.	<u>21</u>			

5. QUESTION NO. INSTITUTIONS

Are volunteers	Yes	<u>18</u>
utilized in your		
vocational	No	<u>55</u>
rehabilitation program?	No ans.	<u>38</u>

Program

6. QUESTION	AGE	NO. INSTITUTIONS
At what chronological age	21	1
do residents begin the	18-20	5
vocational rehabilitation	16-17	31
program ?	14-15	16
	12-13	9
	10-11	3
	5-9	6
	No ans.	15

<u>7. QUESTION</u>	<u>NO. INSTITUTIONS</u>	<u>PERCENTAGE</u>
What percent of the	1	71-75
total population of	2	61-70
your institution is	2	51-60
involved in the	10	41-50
vocational rehabilit-	7	31-40
ation program?	15	21-30
	14	11-20
	20	1-10

<u>8. a. QUESTION</u>	<u>NO. INSTITUTIONS</u>
Have you made many attempts	Yes <u>54</u>
to evaluate and train older	No <u>17</u>
residents from the so-called	No ans. <u>18</u>
"long-term colony" for whom	
there may have been no	
rehabilitation in prior years?	

<u>b. QUESTION</u>	<u>EVALUATION</u>	<u>NO. INSTITUTIONS</u>
What were the results	Limited success or encouraging	<u>4</u>
of this evaluation?		
	Successful	<u>22</u>
	Not successful or discouraging	<u>5</u>
	Program too new to evaluate	<u>2</u>
	No ans.	<u>21</u>

## Training

## 9. QUESTION

## NO. INSTITUTIONS

Do you train for specific jobs, or offer only an evaluation and a general broad training ?	Specific	<u>39</u>
	General	<u>66</u>
	Both	<u>25</u>
	No ans.	9

10. a. QUESTION NO. INSTITUTIONS				b. <u>QUESTION NO. INSTITUTIONS</u>			
Do you provide	Yes	<u>81</u>		Does the	In the		
an on-the-Job				on-the-job	Institution	<u>73</u>	
training programs?	No	<u>4</u>		training program			
No ans. <u>16</u>				take place in	In the		
				the institution	Community	<u>53</u>	
				or community ?			

11. a. Please indicate the areas in which you have residents in your institutional training program.

<u>AREA</u>	<u>NO. RESIDENTS</u>	<u>NO. INSTITUTIONS</u>
Laundry	2,752	73
Kitchen	2,276	69
Hospital	1,675	69
Sewing Rooms	937	68
Maintenance	1,746	66
Dining Room	2,062	63
Cottage Dormitories	1,922	63
Farm Dairy	605	60
Housekeeping	515	60
Other	10,150	60

b. QUESTION    NO. INSTITUTIONS

Does your program	Yes	<u>59</u>
provide for half-day	No	<u>16</u>
training and half-day	No ans.	<u>14</u>
academic program?		

QUESTION    NO. INSTITUTIONS

Is there a	Yes	<u>61</u>
tie-in between	No	<u>15</u>
the rehabilitation	No ans.	<u>13</u>
and education program?		

12. QUESTION    NO INSTITUTIONS

Do you operate	Yes	<u>9</u>
a half-way house ?	No	<u>68</u>
	No ans.	<u>12</u>

Those reporting "Yes"-provided this additional information:

<u>Institution</u>	<u>Average No. Residents</u>	<u>By Whom Supported</u>	<u>Aver. No. Months Stay for Residents</u>	<u>Number on Halfway House Staff</u>
#1	20	State (up to 6 per home)	8-1/2	2
#2	80	On State grounds	36	7
#3 (has 2)	8 12	Initial Cost -Mental Health Fund	6-8	4
#4	12	School	6	6
#5 (has 2)	75	Dept.of Mental Hygiene	12	13
#6	8	School	6-12	0
#7	6	State	12	2
#8	16	Training Center	18-24	5

Placement

13. a. QUESTION NO. INSTITUTIONS

b. QUESTION NO. INSTIT'S NO. WORK

Are any residents working in the community and living-in at the institution?	Yes	<u>36</u>	How many residents work in the community ?	1	164
	No	<u>37</u>		3	80-90
	No ans.	<u>16</u>		1	46-50
				1	36-40
				1	26-30
				2	21-25
				1	16-20
				9	5-10
				6	2-4
				7	1

14. The approximate percentage of residents employed is as follows:

<u>Percentage</u>	<u>No. Institutions</u>
95	1
51-60	6
41-50	6
31-40	6
21-30	11
11-20	24
1-10	13

QUESTION

NO. INSTITUTIONS

15.

If you train residents specifically for work in institutions, do they enjoy Civil Service status and receive pay when transferred to a full-time working situation?

Yes 8  
No 6  
No ans. 20

16. Please list number of trainees who have been removed from your institution into a community living and working situation in the past five years. (This would include those in their own homes, foster homes, etc.)

<u>NO. OUT OF INSTITUTION</u>	<u>NO. OF INSTITUTIONS</u>
1-100	19
100-200	15
200-300	6
300-400	4
400-500	6
500-600	3
700	1
1500+	1
2000+	2

17. Of the total number placed in community institutions within the past five years, what percent have been returned to the institution for some reason?

<u>PERCENT RETURNED</u>	<u>NO. OF INSTITUTIONS</u>
0	1
1-5	9
6-10	15
11-15	4
16-20	7
21-30	6
31-40	4
41-50	4
51-60	1
70-80	3
90	1

18. The three most frequently named explanations for the failure of the institutionalized retarded individuals to adjust successfully to community living are: (a) lack of living facilities, (b) lack of training, (c) competition. Please rank them in the order of severity; the most severe listed first.

<u>Rank</u>	<u>Lack of Living Facilities</u>	<u>Lack of Training</u>	<u>Competition</u>
1.	34	7	19
2.	14	18	32
3.	7	45	18

### III. DISCUSSION OF DATA

#### Personnel

The number of staff has been recorded precisely as reported for several reasons. It would be presumed that in most cases where no answer is given, there is no staff in the vocational rehabilitation department. This figure of 10, coupled with the 43 definite answers of "no staff", means that approximately 52 institutions of the 101 institutions reporting have no vocational rehabilitation staff as they interpreted our question. Twenty-eight (28) institutions have 5 or less in such a department.

The interpretation of this question varied greatly. For instance, the institution reporting 32 full-time staff reports that "the Vocational Department is only partially responsible for the Vocational Rehabilitation Program". It breaks down its full-time staff in this department into two classifications: 10 in the Vocational Department and 22 in the Vocational Rehabilitation Program. The institution reporting 46 on its staff states that "these individuals are employed as full-time supervisory personnel in various vocational areas". The institution reporting 55, brackets its figures with "(School Department)". Any attempt to make these figures meaningful when compared to the question "what percentage of your institution's total population is involved in your Vocational Rehabilitation program?" is impossible. Ratios of the number of staff to the number in the vocational rehabilitation program involve such numbers as 1 to 710, 1 to 599, 1 to 451, etc. Again, there are a number of institutions reporting no staff at all in the vocational rehabilitation department while listing 457, 435, 296, etc. persons as working in various areas such as dining room, kitchen, laundry, etc. Certainly, if their interpretation of this question was the same as the institution listing 46 individuals employed full-time as supervisory personnel in various vocational areas, the figures for this question would be entirely different. There were a few institutions which interpreted this question as applying only to those residents in training in specific areas for possible placement. In these, the ratio of staff to trainee was consistent with the program and did not include supervisory personnel in the working areas of the institution.

Thirty-seven (37) of the institutions indicated that the State provided a counselor for their program. Of the 37 institutions, 8 reported that the counselor was assigned full-time, while 29 indicated that the counselor was assigned part-time. Twelve (12) States did not provide a counselor to 26 of the 30 institutions located within their boundaries.



The majority of the institutions (55) did not utilize volunteers in their vocational rehabilitation program. The 18 institutions who responded in the affirmative used volunteers principally in two areas: providing the transportation and supervision of residents on field trips into the community and taking residents into homes for training in house and yard work. A few reported using volunteers to teach residents how to shop, good grooming, social skills, to make change, measure, etc. Two institutions reported that volunteers were used in Industrial Therapy.

#### Program

Many, (49) of the institutions reported that the vocational rehabilitation program began for residents between 14-17 years of age. Six (6) institutions replied that their programs began for residents between 5-9 years of age and one (1) indicated that its program began for residents 21 years of age.

Twenty (20) institutions responded that from 1-10 percent of their total population was involved in its vocational rehabilitation program, while 14 indicated from 11-20 percent; 15 reported 21-30 percent; 7 reported 31-40 percent; and 10 reported 41-50 percent. Thirty (30) institutions did not respond to this question.

Some of the replies to: "Please give brief descriptions of your effort and the results" were interesting and informative. Examples are as follows:

"20 have been sent out since program started 3 years ago, most of those in the past year. So far none have come back."

"4 placed in jobs in the last 18 months."

"Placements in the Industrial Therapy Section on a 'trial' basis has shown us some results which patients' past history does not indicate to be possible."

"Older residents are somewhat less difficult to place in jobs as community attitudes are more favorable."

"Successful except with those (1) above chronological age 45 or 50; (2) low energy level; (3) unstable personality; (4) admitted to institution before chronological age 8. "

"Several of long term children have been found and placed. Often with good results. We believe that this is a great need in our institution. That is, to re-evaluate the good and faithful

who is often forgotten. "

"Our recent outside placement candidates have had very long residences at the institution — 25 to 30 year residences are not uncommon."

"Usual Rehab activities results discouraging — patients have been institutionalized and habit trained."

"Difficult to place in society."

"Mixed results with some outright refusals to earnest strivers. It would appear that this group is questionable from a feasibility standpoint."

Two institutions reporting "No" as the answer to whether any attempt to evaluate or train the older residents was made, commented as follows:

"Program for these is habilitation - not rehabilitation."

"No. However, individual cases only, not as organized program."

One institution which did not report success or failure made this comment: "Have had regular program for many years. Recently have formed groups of low trainables to sweep streets, pick up grounds, etc."

### Training

Twenty-five (25) of the institutions replied that they train their residents in both specific jobs and general jobs. Nine (9) institutions who returned the questionnaire did not respond to this question.

Some of the institutions reported generally, such as: "Placement of patients in selected training situations in the community." Others were more specific, naming such training situations as drapery shop, lumber yard, hospital, domestics, bottling company, Janitorial service, dish washers, car washers, elevator operators, Western Union Messenger boys, service station attendants, nursing homes, yard up-keep, painter's helper, factory, furniture manufacturing, cafeteria work, library, shoe shop, hospital laundry, clerical work, livestock feeding, farm labor, etc.

One institution described its program as: "Day work continuing up to full-time jobs." Another reported: "Only when training is extended by the Division of Vocational Rehabilitation in such places as Goodwill Industries." 'Another commented: "In specialized shop by the Division of Vocational Rehabilitation." And another: "Two residents presently in community sheltered workshop."

An examination of the responses revealed that many different training areas were being utilized. Some of the employment areas listed were specific. For instance, "kitchen" was broken down into the training areas of bakery, butcher shop, main kitchen, hospital kitchen, etc; maintenance included trash truck, paint shop, grounds maintenance, etc. Other areas of training were: upholstery shop, shoe repair shop, food department, farm, laboratory; general shop such as woodworking, plumbing, metal work, painting; janitorial service, hospital aide, beauty shop, barber shop, office and warehouse. The number of residents listed in each of these training areas was very small in comparison with the number of residents listed by most of the institutions in the areas of employment of the questionnaire.

The number of residents "employed" as reported by the 73 institutions answering this question is 24,640. We believe this figure to be low for the reason, as previously stated, that a number of the institutions reported only those residents working in areas for training prior to placement.

Fifty-nine (59) of the institutions reported that their program provided for half-day training and half-day academic program. Two (2) institutions also reported having evening classes for their residents. Sixteen (16) institutions did not have half-day academic, half-day training programs. Fourteen (14) of the respondents did not answer this question.

Most of the institutions (61) described the tie-in in very general terms such as: team approach; from academic to vocational; included in same departmental set-up; close relationship, etc. Other comments were as follows:

"Coordinated by evaluation committee and the institutional vocational training program to include analysis, placement, etc."

"Teach trade vocabulary, use of measurement, weight, value, tabulating, job attitudes."

"All programs under Director of Training. Classes offer occupa-

tional education and coordinate on-the-job training experience with class work. "

"Administration in one department. Education serves groups of residents. Rehabilitation serves individuals. Much referral and conference about individual cases. "

"The Education Department actively cooperates by making available training and instruction for specific job placement as well as in the standard subjects."

"Work supervisors and instructors cooperate."

"Realistic job experiences are considered in school curriculum. Job supervisors visit the classrooms and students visit work areas."

Of the 15 institutions reporting no tie-in between the rehabilitation and education program, 11 also report no half-day training and half-day academic program; and 6 of these report having no rehabilitation director or staff.

Nine (9) institutions reported that they operate a half-way house. The average number of residents in each half-way house ranged from 6 - 80. The staff ranged from 0 - 13. The institution reporting no staff for its halfway house stated that the residents live alone and are supervised by medical and psychological staff. The average length of stay for the residents ranged from a low of 6 months to a high of 36 months. The ninth institution reporting "Yes" stated that it had a half-way house in conjunction with another State school. However, this institution reported "No", stating that: "Vocational Rehabilitation purchases training from privately operated training center. "

### Placement

Five (5) of the institutions answering "Yes" made no further comments. Three (3) added the following information:

"Those residents who receive these benefits are classified as Institutional Aides."

"At other State institutions as regular State employees." Six (6) of the institutions answering "No", commented as follows:

"Are given \$5.00 per week by Special Legislature Act Chapter 475 of General Laws. Only hospital in State,"

"They are not under Civil Service but they do receive pay."

"Not Civil Service but receive pay on full-time status."

"No, we do not employ patients as employees. Some patients receive a small and varying amount of cash for work done and others work for therapeutic purposes."

"We are in process of instituting a patient reimbursement plan for those who work; however, they will not have Civil Service status

"State Civil Service regulations as presently set up would definitely restrict this."

Looking more closely at some of the institutions answering these questions, we come up with the following facts:

The institution reporting no residents returned, listed 20 as having been removed to community situations. It has 13 teachers for 1,952 residents, no vocational rehabilitation director, none employed full-time on this staff, a part-time DVR counselor, and no volunteers utilized in the vocational rehabilitation program. Residents involved in their vocational rehabilitation program comprise .012 percent of the resident population.

The institution reporting 90 percent returned, listed 88 as having been removed to community situations. It has 15 teachers for 1,806 residents, no vocational rehabilitation director, one Industrial Therapist listed as employed full-time in this department, no DVR counselor and uses some volunteers in its Industrial Therapy Program. Twenty-five percent of the residents are involved in their Industrial Therapy Program.

Another institution with more than 2,000 in residence has a director of academic training, a director of vocational training, 26 supervisors and teachers, 2 teacher aides, 2 industrial therapists, 4 in occupational therapy, 5 psychologists, 13 social workers, and 5 speech and hearing therapists. It reports 21 employed full-time on the staff in vocational department, has a half-day training and half-day academic program with some residents full-time academic and some full-time vocational. It also has a half-way house with a large number of residents and a staff of 7. This institution broke down its figures on residents discharged into two groups: 264 in one and 169 in the group which it considered as having potential or capabilities of community living and working. For the former group, the rate of return to the institution was 12 percent and for the latter group 11 percent.

Another institution reports having sent out into community living and working situation 850 residents in the past five years with 2-1/2 percent returning to the institution. It reports approximately 1,850 residents, 10 teachers on its staff, no director of vocational department, 3 social workers employed full-time on the staff of this department, no DVR counselor, no tie-in between the rehabilitation and education programs, no half-day training and half-day academic program, no half-way house, and no residents working in the community and living-in at the institution until such time as a home in the community is available.

Another institution with approximately 2,300 in residence, 17 teachers, 7 psychologists, 19 social workers, vocational department administered by a trained vocational rehabilitation person, 9 employed full-time on this staff, with a part-time DVR counselor. Five percent of its population is involved in the vocational rehabilitation program. One hundred and fifty-nine (159) have been removed from the institution in the past five years with a return of 9 percent. These figures are for those who have left the institution through its Community Adjustment Unit and does not include those who left to return to their own homes in a living and work situation.

It seems impossible to make any comparisons from the statistics obtained of the number returned to the community and the percentage of return to the institution with the number of staff or coordination of program. On the one hand we have an institution with, seemingly, no formal rehabilitation program and a small staff, which reports a high number of residents removed from the institution and a low percentage of return; on the other hand an institution which seemed to have a good, coordinated vocational rehabilitation program, well staffed in comparison to other institutions, reported few placements and a return of 90 percent. It should be noted, however, that these two institutions differentiated between two types of residents discharged: those having potential or capabilities of community living and working, as distinct from the comprehensive figure of the total number of residents discharged.

#### IV. CONCLUDING REMARKS

Most of the institutions for the mentally retarded have vocational rehabilitation programs. These programs vary greatly among the institutions in the administration, size and kind of staff. However, most of the institutions provide training for their residents in similar areas. For example, laundry, kitchen, hospital, etc. The majority of the institution programs begin for residents 14 to 17 years of age; however, some did have programs for residents under 14 years of age.

Reports from the majority of the institutions indicated 11 to 50 percent of the resident population was involved in a rehabilitation program. Nevertheless, 20 institutions stated that less than 11 percent of their residents took part in such programs. Most of the respondents evaluated their programs for the older or "long-term colony" residents and found these programs successful.

Residents receive broad training in general job areas in most of the institutions with approximately 29 percent of the institutions training their retarded for specific areas of employment, in addition to general preparation. Nearly all programs provide on-the-job training for their residents. The most common training areas utilized by the institutions are: the laundry, kitchen, hospital, maintenance, sewing rooms, dining halls, and dormitories. These training areas are located in the community as well as the institution.

It was evident, however, that the number of residents working in the community was small for most institutions compared to the size of the institution itself and the number of residents in program. The majority of the institutions indicated a lack of living facilities and competition to be the significant factors causing the failure of institutionalized retarded individuals to adjust successfully to community living.

## V. RECOMMENDATIONS

1. More than half of the institutions do not have a trained vocational rehabilitation director for their rehabilitation programs. The vocational rehabilitation program of an institution should be directed by a person trained in this area.
2. Nearly half of the programs have only part-time staff. More important, however, is that many of the institutions reported their staff was not large enough to meet the needs of residents who might benefit from the vocational rehabilitation program. Though full-time personnel is preferable, the main concern is to provide residents with enough staff supervision to meet their needs.
3. Many institutions did not use many volunteers in program. There is a need to encourage the use of volunteers in nearly all of the rehabilitation programs.
4. To facilitate a smooth transition from institutionalized life, to life in the community, it is necessary for institutions to provide suitable living facilities for residents who are placed for employment in the community.



VI. REFERENCE

1. "A Manual on Program Development in Mental Retardation" Monograph Supplement to American Journal of Mental Deficiency. Vol. 66, No. 4 January 1962.

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